Please check off the items below and return this form with your Keiki (Child) Enrollment packet. Mahalo.

- Completed Keiki (Child) Enrollment Form
- Completed Keiki (Child) Emergency and Health Information Form
- Primary Caregiver Emergency and Health Information Form
- Additional Caregiver Emergency and Health Information Form (1 for each participating caregiver)
- Copy of Child’s Immunization Record (do not send originals – copies only please)
- Copy of Child’s Department of Health Certificate of Birth (do not send originals – copies only please)
- Program Participant and Caregiver Release Form for Interviews, Email and Text Messages, Photographs, and Video and Voice Recordings
- Written Stories Release Form
- Keiki Assessment Consent Form
- Caregiver Assessment Consent Form

Keiki T-Shirt size: [ ] Extra Small  [ ] Small  [ ] Medium
Keiki (Child) Enrollment Form

How did you hear about Tūtū and Me? (Please check all that apply) Recruitment Event Code __________

☐ You are a Returning Family     ☐ Referred by a Family Member     ☐ Tūtū and Me Staff Member
☐ Saw Banner or Van Decal       ☐ Other | Describe Other __________________________________________

School Year _________________ Site you would like to attend? ________________________________

Keiki (Child’s) Legal Name ____________________________________________________________

(Please Print) Last First Middle

Sex: (circle one) M F Date of Birth ________________ (Month/Day/Year)

Keiki Home Phone # ____________________________ Emergency Phone # __________________________

Keiki Home Address ________________________________________________________________

No. & Street or P.O. Box City State Zip code

Preferred Mailing Address ____________________________________________________________

No. & Street or P.O. Box City State Zip code

Was this keiki born premature? ☐ Yes ☐ No  If yes, how premature? (In weeks please) _____________

Who does the keiki live with? ☐ Parents ☐ Mother ☐ Father ☐ Grandparents ☐ Other _________________

Is this a Multigenerational Household? ☐ Yes ☐ No  Number of families in the household? ___________

Number of people living in the household? ________  Number of children living in the household? ________

Which child is this? (only, oldest, youngest, middle, etc.) ______________________________________

Primary language spoken at home? _______________________________________________________

Has your keiki recently immigrated to the United States from a country under the Compact of Free Association?

☐ Yes ☐ No (If yes, you will be asked to provide their TB clearance)

Has your keiki ever tested positive for active Tuberculosis? ☐ Yes ☐ No

If yes, has a chest x-ray been taken and has it resulted in a negative result? ☐ Yes ☐ No

Parent’s Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widow/er ☐ Other

Ethnic Ancestry of Keiki

Is this keiki Native Hawaiian? ☐ Yes ☐ No

Please check all other groups the keiki identifies with:

☐ African American ☐ Japanese

☐ Caucasian ☐ Korean

☐ Chinese ☐ Native American or Alaskan Native

☐ Filipino ☐ Pacific Islander

☐ Hispanic ☐ Other

Specify Other ____________________________________________________________
Keiki (Child) Enrollment Form

Parent/Guardian Information

(Check Appropriate Box)  □ Birth Father  □ Step Father  □ Adoptive Father  □ Guardian

Parent Legal Name ______________________________________________________________________________
(Please Print)                      Last                                          First                                          Middle

Employer ____________________________ Email address ____________________________
Business Phone ____________________________

Mobile Phone ____________________________ Email address ____________________________
(☐ check here if you do not wish to receive information about PID via email)

Highest Grade Completed in School  □ Grade 9 or less  □ Some High School  □ GED  □ High School Diploma
□ Associates Degree  □ Bachelors Degree  □ Masters Degree  □ Doctorate Degree  □ Some College

(Check Appropriate Box)  □ Birth Mother  □ Step Mother  □ Adoptive Mother  □ Guardian

Parent Legal Name ______________________________________________________________________________
(Please Print)                      Last                                          First                                          Middle

Employer ____________________________ Email address ____________________________
Business Phone ____________________________

Mobile Phone ____________________________ Email address ____________________________
(☐ check here if you do not wish to receive information about PID via email)

Highest Grade Completed in School  □ Grade 9 or less  □ Some High School  □ GED  □ High School Diploma
□ Associates Degree  □ Bachelors Degree  □ Masters Degree  □ Doctorate Degree  □ Some College

Total Yearly Income of Household:  (Please check appropriate box)

A.  □ Less than $25,000
B.  □ $25,000 to $49,999
C.  □ $50,000 to $74,999
D.  □ $75,000 or more

I hereby certify that the above statements are true to the best of my knowledge and agree to furnish proof and other
documents as requested.

Father/Guardian's Signature ____________________________ Date ____________________________

Mother/Guardian's Signature ____________________________ Date ____________________________
Keiki (Child’s) Legal Name ____________________________________________
(Please Print) Last First Middle
Date of Birth: ___________________________
(month/day/year)

In case of an emergency, please contact one of the following:
(Please list contacts other than attending caregivers)

Name of First Emergency Contact ______________________________________
Relationship to keiki ____________________________________________
Contact number ________________________________

Name of Second Emergency Contact ____________________________________
Relationship to keiki ____________________________________________
Contact number ________________________________

Child's Health Insurance Company ___________________________, Subscribers Name __________________

Child's Physician ___________________________, Physician’s phone number __________________

Has your keiki recently immigrated to the United States from a country under the Compact of Free Association?
☐ Yes (if yes, please provide their TB clearance) ☐ No

Does your keiki receive regular care for any medical conditions? ☐ Yes ☐ No (Please check all that apply)
☐ Allergies ☐ Asthma ☐ Chronic Cough/Wheezing ☐ Diabetes ☐ Heart Disease ☐ Hemophilia ☐ High Blood Pressure
☐ Seizures ☐ Other (please specify) __________________________________________________________

My keiki is allergic to: ____________________________________________________________
Type of Food(s): ________________________________________________________________
Type of Medication: _____________________________________________________________
Other: ________________________________________________________________

Date of last allergic reaction: __________ Description of last allergic reaction: __________

How was the last allergic reaction handled? ______________________________________

My keiki is currently on medication: ☐ Yes ☐ No If yes, the medications are: ____________________________

Is there a need for an Emergency Plan for above identified medical health conditions? ☐ Yes ☐ No

If yes, please specify plan: __________________________________________________________

If my keiki needs to be taken to an emergency facility, he/she will be taken to the nearest facility. I hereby give my consent for the program authorities to take appropriate action for the safety and welfare of my child. ________ Initial

Do you have any concerns about the development of your keiki? ☐ Yes ☐ No

If yes, please describe your concerns: _____________________________________________

Has your keiki received any Early Intervention Services? ☐ Yes ☐ No If yes, referred by: ______________________________

Does your keiki require special accommodations on the program grounds? ☐ Yes ☐ No

If yes, please specify accommodations: ____________________________________________

Father/Guardian’s Signature __________________________, Date __________

Mother/Guardian’s Signature __________________________, Date __________
Primary Caregiver Emergency and Health Information Form

**Primary Caregiver** attending Tūtū and Me (If yes, please check Box) ☐ Keiki Name

Caregiver Legal Name ____________________________
(Please Print)               Last                                      First                         Middle Initial

Caregiver’s relation to the keiki: (Please check appropriate box) ☐ Birth Father  ☐ Birth Mother  ☐ Step Father  ☐ Step Mother
☐ Adoptive Father  ☐ Adoptive Mother  ☐ Hānai Mother  ☐ Hānai Father  ☐ Foster Parent  ☐ Aunt  ☐ Uncle  ☐ Guardian

Language spoken at home ____________________________ Sex: (circle one) M  F  ☐ Are you a grandparent to this keiki? ☐ Yes  ☐ No

Highest Grade Completed in School  ☐ Grade 9 or less  ☐ Some High School  ☐ GED  ☐ High School Diploma  ☐ Associates Degree
☐ Bachelors Degree  ☐ Masters Degree  ☐ Doctorate Degree  ☐ Some College

Home Phone ____________________________ Mobile Phone ____________________________ Email address ____________________________
(☐ check here if you do not wish to receive information about PID via email)

Occupation or Title ____________________________ Employer ____________________________ DOB: ____________________________

Health Insurance Company ____________________________ Primary Care Physician ____________________________ Phone#: ____________________________

Home Address
No. & Street or P.O. Box ____________________________ City ____________________________ State ____________________________ Zip code ____________________________

Informational Survey: ☐ Are you Native Hawaiian? ☐ Yes  ☐ No

In case of an Emergency, please contact one of the following:

Name of First Emergency Contact ____________________________ Relationship to You ____________________________ Contact Phone#: ____________________________

Name of Second Emergency Contact ____________________________ Relationship to You ____________________________ Contact Phone#: ____________________________

Have you recently immigrated to the United States from a country under the Compact of Free Association? ☐ Yes  ☐ No
If yes, you will be asked to provide your TB clearance

Have you ever tested positive for active Tuberculosis? ☐ Yes  ☐ No
If yes, has a chest x-ray been taken and has it resulted in a negative result? ☐ Yes  ☐ No

Do you receive regular care for any medical conditions? Yes ☐ (Please check all that apply) ☐ No Medical Conditions
☐ Allergies  ☐ Asthma  ☐ Chronic Cough/Wheezing  ☐ Diabetes  ☐ Heart Disease  ☐ Hemophilia  ☐ High Blood Pressure
☐ Seizures  ☐ Other (please specify) ____________________________

I am allergic to: Food(s): ____________________________ Medication: ____________________________

Other (chemical, dust, etc.): ____________________________

Date of last allergic reaction: ____________________________ Description of last allergic reaction: ____________________________

How was the last allergic reaction handled? ____________________________

I am currently on medication: ☐ Yes  ☐ No  If yes, the medications are: ____________________________

Is there a need for an Emergency Plan for above identified medical health conditions? ☐ Yes  ☐ No
If yes, please specify plan: ____________________________

If I need to be taken to an emergency facility, I hereby give my consent to be taken to the nearest location and for the program authorities to take appropriate action for my safety and welfare. ☐ Yes  ☐ No ________Initial

Do you have any criminal convictions or history of child abuse or neglect or psychological or psychiatric problems that may adversely affect or interfere with the health, safety or well-being of children? ☐ Yes  ☐ No ________ Initial I understand that checking “no” does not preclude Partners in Development Foundation from conducting a criminal background check and/or request for additional personal information to conduct the criminal background check

I certify that the information submitted on this form is true and correct and hereby consent that Partners in Development Foundation has my permission to conduct a criminal background check.

Caregiver’s Signature ____________________________ Date ____________________________

© Partners In Development Foundation  All Rights Reserved  Revised 08/11/16
Additional Caregiver Emergency
and Health Information Form

*Additional Caregiver attending Tūtū and Me (If yes, please Check Box) □ Keiki Name

Caregiver Legal Name ____________________________ (Please Print) Last ____________ First ____________ Middle Initial ____________

Caregiver’s relation to the keiki: (Please check appropriate box) □ Birth Father □ Birth Mother □ Step Father □ Step Mother
□ Adoptive Father □ Adoptive Mother □ Hānai Father □ Hānai Mother □ Foster Parent □ Aunt □ Uncle □ Guardian

Language spoken at home ____________________________ Sex: (circle one) M □ F □ Are you a grandparent to this keiki? □ Yes □ No

Highest Grade Completed in School □ Grade 9 or less □ Some High School □ GED □ High School Diploma □ Associates Degree
□ Bachelors Degree □ Masters Degree □ Doctorate Degree □ Some College

Home Phone ____________ Mobile Phone ____________ Email address ____________ Text: check here if you do not wish to receive information about PID via email)

Occupation or Title ____________________________ Employer ____________________________ DOB: ____________ month/day

Health Insurance Company ____________________________ Primary Care Physician ____________________________ Phone# ____________

Home Address No. & Street or P.O. Box ____________________________ City ____________________________ State ____________________________ Zip code ____________

Informational Survey: □ Are you Native Hawaiian? □ Yes □ No

In case of an Emergency, please contact one of the following:

Name of First Emergency Contact ____________________________ Relationship to You ____________________________ Contact Phone# ____________________________

Name of Second Emergency Contact ____________________________ Relationship to You ____________________________ Contact Phone# ____________________________

Have you recently immigrated to the United States from a country under the Compact of Free Association? □ Yes □ No

If yes, you will be asked to provide your TB clearance

Have you ever tested positive for active Tuberculosis? □ Yes □ No

If yes, has a chest x-ray been taken and has it resulted in a negative result? □ Yes □ No

Do you receive regular care for any medical conditions? □ Yes □ No (Please check all that apply) □ No Medical Conditions
□ Allergies □ Asthma □ Chronic Cough/Wheezing □ Diabetes □ Heart Disease □ Hemophilia □ High Blood Pressure
□ Seizures □ Other (please specify) ____________________________

I am allergic to: Food(s): ____________________________ Medication: ____________________________ Other (chemical, dust, etc.): ____________________________

Date of last allergic reaction: ____________ Description of last allergic reaction: ____________________________

How was the last allergic reaction handled? ____________________________

I am currently on medication: □ Yes □ No If yes, the medications are: ____________________________

Is there a need for an Emergency Plan for above identified medical health conditions? □ Yes □ No

If yes, please specify plan: ____________________________

If I need to be taken to an emergency facility, I hereby give my consent to be taken to the nearest location and for the program authorities to take appropriate action for my safety and welfare. □ Yes □ No Initial

Do you have any criminal convictions or history of child abuse or neglect or psychological or psychiatric problems that may adversely affect or interfere with the health, safety or well-being of children? □ Yes □ No Initial I understand that checking “no” does not preclude Partners in Development Foundation from conducting a criminal background check and/or request for additional personal information to conduct the criminal background check

I certify that the information submitted on this form is true and correct and hereby consent that Partners in Development Foundation has my permission to conduct a criminal background check.

Caregiver’s Signature ____________________________ Date ____________________________

© Partners In Development Foundation All Rights Reserved Revised 08/11/16
Program Participant and Caregiver Release Form for Interviews, Email and Text Messages, Photographs, and Video and Voice Recordings

I, ___________________________, understand that Partners in Development Foundation (PIDF) uses interviews, email and text messages, photographs, videos, and voice recordings of participants taken during preschool, school, and other related events as a means of education, evaluation, documentation, and to raise public awareness of its services.

I authorize PIDF and its designated agents, to interview, photograph, record, film, and videotape me and/or the minor children in my care.

I further authorize PIDF to use, televise, and publish (in print or on the Internet, including Facebook and other social media) such interviews, email and text messages, photographs, videos, and voice recordings for any purpose which PIDF deems suitable and which is consistent with the mission of PIDF. I agree that no representations or warranties have been made regarding the purpose or use of my interviews, email or text messages, photographs, videos, or voice recordings, except for those set forth in this release.

On behalf of myself, my heirs, executors, administrators, legal representatives, and assigns, I release and forever discharge PIDF and its Board of Directors, officers, agents, and employees from any and every claim, demand, action, in law or equity that may arise as a result of PIDF’s use or publication (through print, Internet, or television) of its interviews, email or text messages, photographs, voice recordings, films, or videotapes of me and/or the minor children in my care.

I further state that I have carefully read the terms of this release. I understand that I am signing a complete release and bar to any claim resulting from PIDF’s use or publication of interviews, email or text messages, photographs, voice recordings, videos and other forms of media described herein of me and/or the minor children in my care.

I further understand that this release shall survive the termination of my relationship with PIDF for all media described herein and created during said relationship.

☐ I agree to all of the above.

☐ I disagree, and do not authorize PIDF to interview, photograph, videotape or record me or the minor children in my care for any of its purposes.

____________________________   _______________________
Program Participant or Caregiver’s Signature   Date
Written Stories
Release Form

From time to time Tūtū and Me uses stories from families as a means of education, evaluation and documentation. By signing below you give permission to Tūtū and Me to post and/or publish your story(ies) in print or on the Internet for the purposes of education, evaluation and documentation.

The undersigned gives permission to Tūtū and Me to post and/or publish written documents (i.e. story/ies) by the following family members:

I _____________________________ (parent/guardian), certify that I am legally authorized to approve this on behalf of _____________________________ (child).

_________________________________  _____________________________  ____________________________
Parent or Legal Guardian  Signature  Date

☐ Please check this box if you do not want your story(ies) used on our web site.
Tūtū and Me Traveling Preschool
Keiki Assessment Consent Form

I, the undersigned, consent to participation of my child in the assessments at Tūtū and Me Traveling Preschool. I understand that none of the information gathered through these assessment measures will be presented in a way that links it specifically with my name or the name of my child. My responses, and my child's responses will be kept confidential by the Tūtū and Me program staff.

I, ________________________________ certify that I am legally authorized and approved to sign on behalf of my child, ________________________________.

(Print Name of Parent or Legal Guardian)

(Print Name of Child)

_________________________________  _______________________
Signature of Parent or Legal Guardian          Date
Tūtū and Me Traveling Preschool
Caregiver Assessment Consent Form

I, the undersigned, consent to participation in the assessments at Tūtū and Me Traveling Preschool. I understand that none of the information gathered through these assessment measures will be presented in a way that links it specifically with my name or the name of my child. My responses, and my child’s responses will be kept confidential by the Tūtū and Me program staff.

I, ________________________________, am attending the program with
(Print Name of Caregiver Attending Program)

______________________________
(Print Name of Child)

__________________________  ____________
Signature of Attending Caregiver   Date