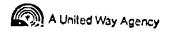


Alternatives To Violence: East Hawaii P.O. Box 10448 • Hilo, Hawaii 96721-5448 • (808) 969-7798 • Fax 961-3202

TO:	DATE: 2-26-98. FAX #:
NUMBER OF PAGES (including this cover sheet) _ COMMENTS:	
COMMENTS:	
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THIS COMMUNICATION IS INTENDED SOLELY FOR THE INDIVIDUAL OR THE ENTITY TO WHICH IT IS ADDRESSED. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE NOTIFY US IMMEDIATELY BY TELEPHONE AND RETURN THE ORIGINAL MESSAGE TO US AT THE ADDRESS ABOVE VIA THE U.S. POSTAL.



CSR ABUSE INTER

FOR EACH QUESTION, FILL IN THE NUMBER THAT BEST DESCRIBES YOUR RELATIONSHIP

3=FREQUENTLY 2=SOMETIMES 1=RARELY 0

- DOES HE CONSTANTLY CHECK ON YOU AND MAKE YOU ACCOUNT FOR EVERY MINUTE
 YOUTH NOT WITH EIM (ERRANDS: VISITS PRIENDS, GOES TO WORK, GOES OUT, ETC.)
 - 2. LOES HE EVER ACCUSE YOU OF HAVING AFFAIRS WITH OTHER MEN OR ACT SUSPICIOUS OF YOU?
 - 3. IS HE EVER RUDE TO YOUR FRIENDS?
 - 4. HAS HE EVER DISCOURAGED YOU FROM STARTING FRIENDSHIPS WITH OTHER WOMEN BY CALLING THEM NAMES, TELLING YOU HE DOESN'T WANT YOU TO HANG AROUND THEM-BAD INFLUENCE
 - 5. IS HE EVER CRITICAL OF THINGS SUCH AS YOUR COOKING, YOUR CLOTHES, OF YOUR APPEARANCE
 - 6. DOES HE DEMAND A STRICT ACCOUNT OF HOW YOU SPEND MONEY?
 - 7. DOES HIS MOODS CHANGE FROM VERY CALM TO VERY ANGRY OR VICE VERSA?
 - 8. IS HE DISTURBED BY YOUR WORKING OR THE THOUGHT OF YOU CETTING A JOB?
 - 9. DOES HE BECOME ANGRY MORE EASILY WHEN HE DRINKS?
 - 10. DOES HE PRESSURE YOU FOR SEX MUCH MORE OFTEN THAN YOU LIKE
 - _11. DOES HE BECOME ANGRY IF YOU DO NOT WANT TO GO ALON; WITH HIS REQUESTS FOR SEX?
 - 12. DO YOU AND YOUR FARTNER QUARREL MUCH OVER FINANCIAL MATTERS
 - 13. DO YOU AND YOUR PARTNER QUARREL MUCH ABOUT HAVING CHILDREN OR HOW TO RAISE THEM
 - 14. DOES HE EVER STRIKE YOU WITH HIS HANDS OR FEET (SLAP, PUNCH, KICK, ETC.)

G=FREQUENTLY S=SOMETIMES G=TARTLY C=NEVER

- 15. DOES HE EVEF STRIKE YOU WITH OBJECTS
- 16. DOES HE EVER THREATEN YOU WITH AN OBJECT OR WEAFON
- _17. HAS HE EVER THREATENED TO KILL EITHER YOU OR HIMSELF
- 18, HAS HE EVER GIVEN YOU VISIBLE INJURIES (SUCH AS WELTS, BRUISES, CUTS, ETC.)
- _19. HAVE YOU EVER HAD TO TREAT ANY INJURIES FROM HIS VIOLENCE WITH FIRST AID
- _20. HAVE YOU EVER HAD TO SEEK PROFESSIONAL AID FOR ANY INJURY AT A MEDICAL CLINIC.
 DOCTOR'S OFFICE, HOSPITAL, OR EMERGENCY ROOM
- _21. HAS HE EVER HURT YOU SEXUALLY OR MADE YOU HAVE SEX AGAINST YOUR WILL
- _22. IS HE EVER VIOLENT TOWARD CHILDREN
- 23. IS HE EVER VIOLENT TOWARD OTHER PEOPLE OUTSIDE YOUR HOME AND FAMILY
- _24. DOES HE EVER THROW OBJECTS OR BREAK THINGS WHEN HE IS ANCRY
- 23. HAS HE EVER BEEN IN TROUBLE WITH THE POLICE
- 26. HAVE YOU EVER CALLED THE POLICE OR TRIED TO CALL THEM BECAUSE YOU FELT YOU OR MEMBERS OF YOUR FAMILY WERE IN DANGER.

ADAITED FROM THE "CSR ABUSE INDEX" IN THE FAMILY SECRET BY WILLIAM A. STACEY AND ANSON SHUFE.

ALIĒTNATINIS 10 VIOLENC BATTURER'S PROGRAM INTAKE

ABUSE INDEX SCORE

TO SCORE CAR ABUSE INDEX FORM RESPONSES, SIMPLY ADD UP THE POINTS FOR EACH QUESTION. THIS SUM IS THE ABUSE INDEX SCORE.

COMPARE INTEN SCORE WITH THE FOLLOWING CHART!

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(a) (34-13	MUDERATELY ABUSIVE
	12-0	NONABLSIVE,

ADAPTED FROM THE "CSR ABUSE INDEX" IN THE PAMILY SECRET BY WILLIAM A. STACEY AND ANSON SHUF

DHS 1269 (rev 02/96)

		REQUEST FOR COPY OF	VITAL STATISTICS R	ECORD DEPARTMENT	TOTHUMAN SERVICES
TO:	State Registrar Office of Health S State Department P. O. Box 3378 Honolulu, Hawaii	of Health 96801		APP	DIVISION D 9 1998 VASSESSMENT UNITY D, HI 76720
L.	The Family and A	dult Services Division, requests	copy(ies) for offici	al use:	
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	[DEATH:	Full Name of Deceased Date of Death	Place	Hilo, HY	
	[] MARRIAGE	Full Name of Groom Full Name of Bride Date of Marriage			
	[] DIVORCE:	Full Name of Groom Full Name of Bride Date of Divorce			
П.	[] Required by I	tigation of possible fraud/overpay Probate Court to establish deceder [tigation of child abuse/neglect [nt's estate 1 Termination of parents	al rights of dependent adult a	buse/neglect
III.		ATURE: Name of Requestor	_	Title Sec.	
SENI ADD	ONE ORIGINAL	take Assessment Telephon Livit AND ONE COPY TO DEPART PE STAMPED OR MARKED "	MENT OF HEALTH (2d	Date 5 5 5 5 5 5 5 5 5 5	H SELF-
ſ٧.	DEPARTMENT	OF HEALTH (Fill in below if rea	quest cannot be met):		
	Copies requested	above cannot be furnished because	SE		
	plete three (3) copies		State Registrar Office of Health Status	s Monitoring	
Origin	nal and copy to DOI	1; copy-case record			

BY_





STATE OF HAWAII

DEPARTMENT OF HUMAN SERVICES

KATHLEEN G. STANLEY
DEPUTY DIRECTOR

Social Services Division 120 Pauahi Street, Suite 210 Hilo, Hawaii 96720 Telephone: (808)933-0350

April 7, 1998

When replying, please address to Acting CWS Section Administrator

Christopher E. Barthel, Ph.D. 56 Waianuenue Avenue Hilo, Hawaii 96720

Re: KEMA, Jaylin M. KEMA, Peter J.

Dear Dr. Barthel:

The Kema family was referred to Child Protective Services (CPS) for possible physical sexual abuse of Mr. and Mrs. Kema have informed us that you are their provider of mental health services. We have enclosed a copy of a consent for the release information regarding their family signed by Mr. and Mrs. Kema.

We are interested in obtaining a written report of your case record information, as well as your impressions of this family. Information which may be helpful include date of referral, initial diagnoses, progress and treatment recommendations.

Your cooperation is greatly appreciated. Should you have any questions or concerns, please call me at

Sincerery

, Social Worker IV East Hawaii Intake/Assessment

Unit

Approved by:

Acting CWS Section Administrator

APR. 1 3 1998

EH INTAKE ASSESSMENT UNIT HILO, HI 96720

DEPARTMENT OF HUMAN SERVICES
SOCIAL DEPARTMENT OF HUMAN SERVICES
SOCIAL DEPARTMENT OF HUMAN SERVICES

KATHLEEN G. STANLEY

DEPUTY DIRECTOR



STATE OF HAWAII

DEPARTMENT OF HUMAN SERVICES

Social Services Division 120 Pauahi Street, Suite 210 Hilo, Hawaii 96720 Telephone: 933-0350

April 29, 1998

Lt. Ronald Nakamichi Hawaii Police Dept./JAS 349 Kapiolani Street Hilo, HI 96720

Re:



Dear Lt. Nakamichi,

As requested by you, this is to confirm DHS' request for police stand-by assistance on April 22, 1998 for the removal of from their respective schools.

This request was made based on the decision by DHS to exercise the jurisdictional authorization awarded to us by Family Court Judge Ben Gaddis on March 23, 1998. At the hearing on that date, Judge Gaddis awarded Temporary Family Supervision to DHS which, according to HRS 587, gives us the authority to place children in our care without further order of the court or police Protective Custody. Note that with an order of Temporary Family Supervision, the legal status of automatically converts to Temporary Foster Custody upon the removal of from the care of the parents.

Sincerely,

East Hawaii Intake/Assessment

Approved by:

Acting Section Administrator, EHCWSS

bcc: Murai, Dagy

AN FOULL 655

BENJAMIN J. CAYETANO GOVERNOR

SUSAN M. CHANDLER, M.S.W., Ph DIRECTOR KATHLEEN G. STANLEY

DEPUTY DIRECTOR

DEPARTMENT OF HUMAN SERVICES FAMILY AND ADULT SERVICES DIVISION **FACSIMILE COVER SHEET**

STATE OF HAWAII

Today's Date:	Total No. of Pages including Cover Sheet:
To:	Made the white was the wife
Address:	I profession of the
Phone Num	ber: Marie Marie Fax Number: Marie M
From:	DARS/CAS
Address:	120 Panel # 210
Phone Numbe	
Subject:	•
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WARNING: This message is intended only for the use of the individual to which it is addressed and may contain information that is priviledged or confidential. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error please notify us immediately by telephone, and return the original to us at the above

CONSENT TO RELEASE OF INFORMATION TO THE DEPAR . MENT OF HUMAN SERVICES, FAMILY AND ADULT SERVICES DIVISION

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	(2) Individual/agency or orga		A Company of S	o give the following information
	FAMILY AND ADULT S		rd (check as approp	riate) to the DEPARTMENT OF
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provided for i action has bee date on which I further unde	in the regulations. I also un en taken in reliance on it, ar h I sign this consent.	derstand that I may revolute that in any event this the disclosure authorized	oke this consent at a consent expires aut I berein is to enable	vritten consent unless otherwise my time execpt to the extent that omatically one year from the the service providers to facilitate following service provider:
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(8) A4	ICTUD HILO			Security No. or Birthdate liceas/Recipient
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Alternatives To Violence: East Hawaii P.O. Box 10448 • Hilo, Hawaii 96721-5448 • (808) 969-7798 • Fax 961-3202

TO: <u>CPS</u>	DATE: 2-26.98.
ATTN:	FAX
FROM: <u>Karen</u> - A TU PHONE: 969-7798 FAX#:	· ·
NUMBER OF PAGES (including this cover sheet)	82.
COMMENTS:	
() For information/files () For signature and distribution () For your review and conuncuts () For distribution () For recording/filing () For filing () For signature and return () See above remarks	For your action Per your request Per our conversation For your approval Approved as noted Disapproved For correction

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15. How long have you been an this relationship	? Yearsa Notice The Care to the
14. Are you married to this partner?	the senantition because of vicience? ics
17. If you are separated from this partner, was	alonge In Olla
18. Have you ever separated before hecause of von 19. What contact do you have with this partner	who has been violent with you?
19. Was contact so you have with	breing togother -

EAST HAI KEIASSESSMENT UNIT 120 Paual, Standard Ho. Mt. 96770 Telephone



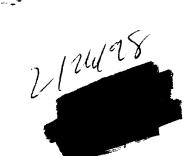
Fax

To: Bay	- Clinic	Fron		
Fax: 96	1-4795	Page	s: 3	
Phone: 9(19-1427	Date:	02/25/98	
Re:				
□ Urgent	Ģ For Review	☐ Please Comment	☐ Please Reply	☐ Please Recycle

e WARNING: This message is intended only for the use of the individual to which it is addressed and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error please notify us immediately by telephone, and return the original to us at the above address.

MAR 2 0 1998

EH INTAKE/ASSESSMENT UNIT HILO, HI 96720



CONSENT TO RELEASE OF INFORMATION <u>TO</u> THE DEPARTMENT OF HUMAN SERVICES, FAMILY AND ADULT SERVICES DIVISION

To be Mariecee Kons	.
(1) Name of applicant/recipiens/legal guardian (A.S.)	bereby give my permission to
Ben Medred Clinie	to give the following information
(2) Individual/agency or organization	
in their records aboutme and/ormy family and/or my ward [cl	ock as appropriate to the DEPARTMENT OF
HUMAN SERVICES, FAMILY AND ADULT SERVICES DIVISION.	
The information to be reviewed/released is limited to the following:	ter 2 h - may t
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lost 2 years. media	e problem)
frotties oprains cut	of (acute care)
18hot - up to date? lost in	ned that mad pur
This information is to be used for DHS CPS O	-comet
	(4) State purpose
(5) Check one of the following: [to exceed 90 days from date signed); OR
[] FOR RESIDENTS OF DRUG AND ALCOHOLIC TREATMENT CE I understand that my records are protected under the federal regulation Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclose provided for in the regulations. I also understand that I may revoke the action has been taken in reliance on it, and that in any event this considered on which I sign this consent.	ns governing Confidentiality of Alcohol and d without my written consent unless otherwise his consent at any time except to the extent that
I further understand that the purpose of the disclosure authorized here assessment and treatment. I authorize the DHS to redisclose the information of the control of the c	
1.	· .
(7) Signature of applicant recipiers/logal guardian	1×1/9/98
\mathcal{V}	
4 P.O. Bx 10742, Hilo, H1 96721	
(2) Address of applicant recipient	Social Security No. or Birthdate of Applicant/Recipient

Complete two (2) copies:

Original - Individual/agency, Copy - Case record

DF 1485 (6/-4)

WED 15:45 FAX 808 933 0364 EHIA UNIT. **2**003 ist Service Totake - Assessment Unt (Child Protective Services) mon/LSw Sw. Jeb. 25 98. Appointmet | medicif Chronia med.

Appointmet | Complaint | West: TK.

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DEPARTMENT OF HUMAN SERVICES SO HOUSE DIVISION

MAR 2 3 1998

EH INTAKE/ASSESSMENT UNIT HILO, HI 96720

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U/26/98

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Signature			Date of	examina	ition

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Bay Clinic Community Health Center WELL-CHILD RECORD S.JEM 4 Years

Pahoa Family Health Center

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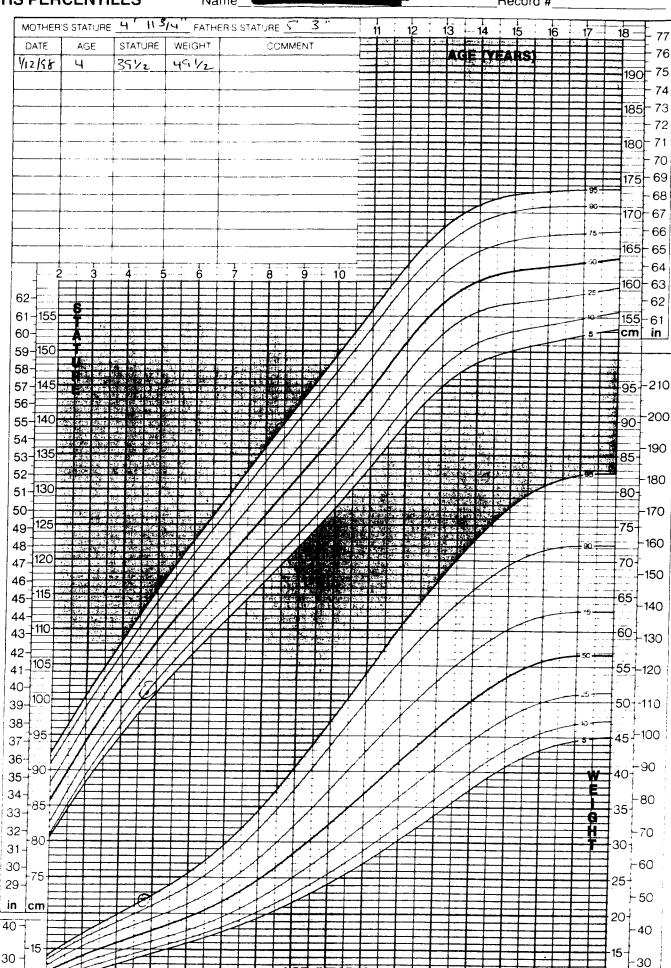
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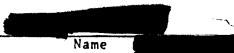
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Ross Products Division, Abbott Laboratories



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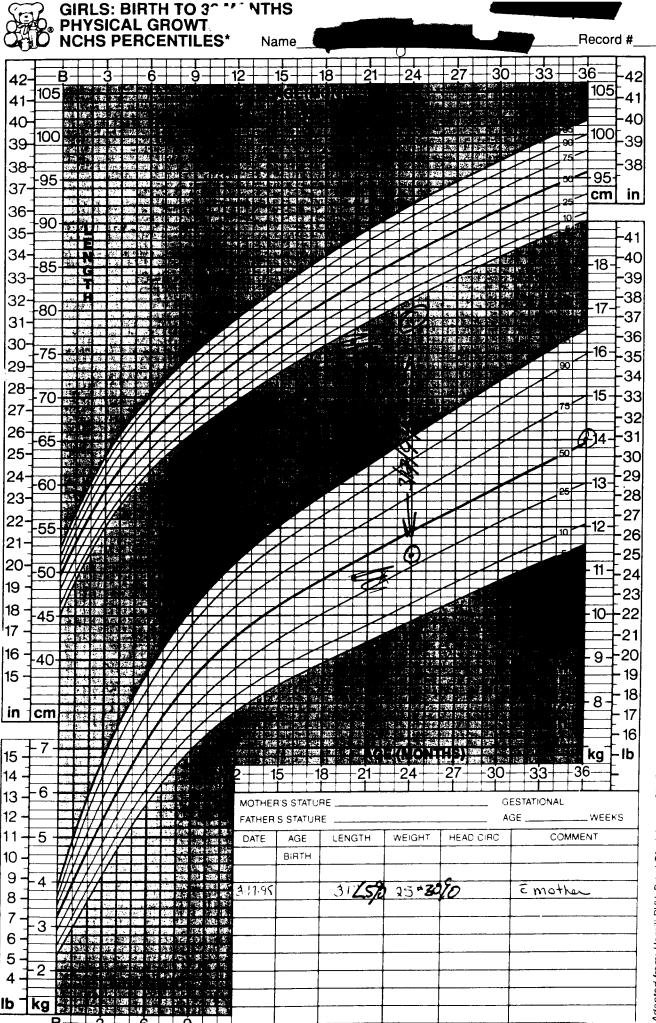
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Bay Clinic Community Health Center WFLL-CHILD RECORD SYSTEM Pahoa Family Health Center 3 Years

Age in years			· ·	$\Delta_{i} = 1/N_{i} + O_{i}$
Interval History				3.20.96
		Addressed/WNL X Abnormal/See Comments Not Adhressed Examination		mont objete over the parties
Illnesses/accidents Other	[] 22 23 24	1. WT 31 9 %	42. <u>C</u>	fritstatus fritstatus ly S/Lu
 Utrition 3. Diet varied/no junk food 4. Vitamins 5. Fluoride	27 [] 28 [] 29 [] 30 [] 31.	· Fundi	l3. Chole if indi	ng/immunizations esterol and nutrition advice cated by positive
7. Imaginary friend talks w 8. Copies circles 9. Follows simple directions 0. Knows full name, age, sex 1. Knows 1 color LEO 2. Uses plurals 3. Broad jump 4. Rides tricycle	33. 34. 35. 36. 37. 38. 39. 39.	Teeth-gums Neck Lungs R 26 Heart R // D Abdomen Genitalia	4. Plan5. Day c 6. Discip 7. Play: a	Icipatory Guidance Lawar remained of the lawar sectivities, reading, aits and supervision
5. Raising siblings 6. Playmates 7. Family changes 8. Family joint activities 9. Family history of early MI, histo	1 Ten 41	How does parent describe child? 50 51 52 53	 Sex ed Sleep: enures Speec Toilet t Nutrition Safety: water 	ducation, masturbation nightmares, night-terrors, sis
Mon IPPN		abnormal findings below. Use reference numbers.		
25 7 mmu chy frah 30 both cen	rd Nd		int.	-Hi>1
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11:05 a.m
11-9-9-1 w+ 24# H+: 28" Age: 20 mos = mo.
T: QU.1 (AK) P! 102
6. Janu Gunday Varon Granted & mosquito bute on 11/2/94.
Impetizo te miatria e extremities, somach, some on puttoles.
Welds Hab for W.C. HEB 10.4 glal.
Pass Provider Dr Wilson
D: PS ALONAD
Skin & ext, wasse leg & expluenchais Figitos
A lew hory wided prices
N'impelige
P'-Mariailla 145mg/sn/ TID x 7day
- But when FID
- THE COLPE LYIN
+WISCHO! Process
03-13-95 From
3-17-95 25# 31" 24mo/wk & Emother & Mydrocontison Cume
11:15 Am T. 94.9° (ax) P134 R42 H.C. 183/4"
S. Well baby V RTC Tuesday for H+H = LOAD TEST.,
LAB reg given to mother, imm. current to date.
5) Child has clusing dy suing condition
which nother treats & Hydrocort Bermox
moldferryex cremo, Father Teguna.
Herefor
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STATULE LESTO LIST 30%
A . H
D. O.M



ROSS

SIMILAC * WITH IRON

First choice of more physicians and used in more hospitals

ISOMIL*

First choice of more physicians for milk-free feeding

PediaSure*

The only complete nutritional formula designed for children 1 to 10 years old

Pedialyte*

Oral Electrolyte
Maintenance Solution

Quickly restores fluids and minerals lost in diarrhea and vomiting

VI-DAYLIN¹

Good-tasting vitamins for infants and children

Noche AF, Moore WM: Physical growth: National Center for Health Statistics percentiles. AM J CLIN NUTR 32:607-629, 1979. Data from the Fels Longitudinal Study, Wright State University School of Medicine, Yellow Springs, Ohio. Ross Products Division, Abbott Laboratories 1982

KAMA, WILLIAM, MD (12914) 311 KALANIANAOLE AVE. HILO, HI 96720 969-1427

Ordering Phys: DE LUE, NATALIE



Clinical Laboratories of Hawaii

' ORATORY REPORT

(808) 974-6898 (SC)

PATIENT ID

PATIENT ID

SSN:

SEX REPORT DATE 01/15/98

ZOP

PAGE: 1

Accession: H64512/A893667 Collected: 01/15/98 9:35

RESULTS ABNORMAL

REFERENCE RANGE U

UNITS

Hemoglobin

13.8

(11.2-14.2)

g/dL

FINAL REPORT

Additional Copy. Test(s) originally ordered by: DE LUE, NATALIE, MD



MCALISTER, ROBERT, MD

11295

PO BOX 1455

PAHOA, HI 96778 PH# 808-965-9711 (

ORDERING PHYS: MCALISTER, ROBERT



Clinical Laboratories of Hawaii

(808) 677-7999

- 1854 FEBOS / 9245 7 9 7

+ 145:00

MOP

PATIENT TEL NO:

ACCESS NO. T55294 COLL:03/25/97, 09:50

Automated Bld	Cnt	
MG COMPLEG DIG	CILC	

WBC	8.2			6.0-17.0	10(6)/L
RBC	4.99			3.5-5.5	10(9)/L
Hemoglobin	13.9			11.2-14.2	g/dL
Hematocrit		39.6	H	33.0-39.0	Ž.
MCV	79.3			71-91	fL
MCH	27.8			22-32	pg
MCHC	35.1			31-37	g/dL
RDW	11.2			11-15	7.
Platelet Count		387	H	212-338	10(6)/L
Comment					

37C Results; Possible cold agglutinins

****END OF REPORT***

Clinical Laboratories of Hawaii

MCALISTER/MD, ROBER, P O BOX 1455

PAHOA

TENT NAME

MARKS

HI 96778

Copy to: WIC-HILO BRANCH



Clinical Laboratories of Hawaii

(808) 935-4814

Locn: MOP

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PAGE 1

PHONE#/MED RECH

GOTTEGREG: VAN VAN DO TVV

Resulted: 04/04/96

TEST	RESULT	UNITS REF	ERENCE RANGE	LAB
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APR 8 '96 8:03

McALISTER/MD, ROBER.

P 0 80X 1455 PAHOA

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ORATORY REPORT®01/001

Clinical Laboratories of Hawaii

(808) 935-4814

Locn: MOP

04/08/96

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PAGE

Resulted: 04/07/96

TEST

RESULT

UNITS

REFERENCE RANGE

LAB

LEAD, BLOOD

7

ug/dL

< 10

00

Insurance : Quest

Ethnic group: CHINESE/FIL/HAWN/JAP

PATIENT ID

Zip Code : 96778

LABORATORY REPORT

REFERRING PHYSICIAN
BAY CLINIC PAHOA
P.O. BOX 1455
PAHOA, HI 96778



DR. MCALISTER, ROBERT HOSF #:

PAT.TEL.NO:

MEDICAL DIRECTOR DAVID SHIMIZU, M.D.

		DATE BEDORTED
DATE COLLECTED	DATE RECEIVED	DATE REPORTED
03/24/95	03/24/95	03/24/95!
1 2 7 2 1 - 1		10 -07
10:00		16:07

ACCESSION NUMBER
E6151787
PAGE 1

TESTS

RESULTS

REFERENCE VALUES

H & H

Hemoglobin Hematocrit 12.9H g/dL 38.0 1/L 10.8-12.8 35.0-43.0

H&H PERFORMED AT DLS/ACCUPATH HILO LABORATORY.

*** FINAL REPORT ***

RECEIVED MAR 2 8 1995



ADDITIONAL COPY FROM: CHILDHOOD LEAD POISONING

REFERRING PHYSICIAN
CC: BAY CLINIC FAHOA
F.O. BOX 1455
FAHOA, HI 96778

LABORATORY REPORT



REPRINT:

DR. MCALISTER, ROBERT

PAT. TEL. NO:

MEDICAL DIRECTOR DAVID SHIMIZU, M.D.

 DATE COLLECTED
 DATE RECEIVED
 DATE REPORTED

 03/24/95
 03/24/95
 03/28/95

 NO TIME
 3:11AM

ACCESSION NUMBER
E6162011
PAGE 1

TESTS

RESULTS

REFERENCE VALUES

Lead, Blood

7

ug/dL

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PLEASE NOTE: BAY CLINIC PAHOA This is an ADDITIONAL REPORT for-P.O. BOX 1455
*** FINAL REPORT ***

RECEIVED MAR 2 8 1999



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PUPIL'S HEALTH RECORD

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	•	Ad	ult Physical	Assessme	nt	
Patient Name:			Date of 1	Birth:		
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Height: 5014 Weight: 68			Pulse: 7		7	_
Temperature: 99.	^			ions: 20 essure:	Med	_
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Reason for Visit (subject of the subject of the sub	epst.	· /	/ 5: na	PV sed be	Rose for EPSOV	
Pertinent Physical Fine Hearing	or i	mer /				
System	Normal	Abnormal	Not Examined	Refer	Comments (required for any referral)	,
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WELL-CHILD RECORD SYSTEM Bay Clinic Community Health Center 6 - 8 Years Family Health Center Name Date of visit Age In years Grade 115158 KEY: Addressed/WNL Abnormal/See Comments Not Addressed interval History Key Family Checks (Continued) V Temperament 1. Concerns... 24. Family history update 51. Describe child's mood/affect 2. Illnesses..... 25. Family Interactions 4. Physical activity 5. Problem habits 28. Alert for child abuse/neglect ... Assessmen 6. Other 29. Any firearms at home Physical Examination 30. wт 💪 'Я 31. HT 50 1/4 7. Diet 32. BP 96/54 Screening/immunizations 33. Temp 99. 53. Remain alert for vision and 9. Fluoride 34. Skin . hearing problems 11. Eating habits 14 36. Head 54. Plan Development 37. Eyes..... 38. Fundi 55. Allowance 39. Ears 56. Limit setting, 40. Nose 19 discipline without anger 58. TV monitoring. 17. Reads for pleasure advertising caution 18. School work . Sometimes ... [4 44. Lungs...... 59. Nutrition: snacks, breakfast qd.. 60. Safety: bike, car, personal 61. Dental hygiene and Key Family Checks 47. Genitalia 21. Marital changes Parent Seport 48. No signs of puberty 62. Exercise/appropriate weight 22. Recent move ... 6/97 49. Musculoskeletal..... 63. Chores, responsibilities..... 64. Shared activities with parents... Detail all abnormal findings below. Use reference numbers. Kekents adult size portime. Physician signature RTO In years See written progress note

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Re-Visit Plan:

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GIRLS: 2 TO 18 YEARS PHYSICAL GROWTH NCHS PERCENTILES

Record #



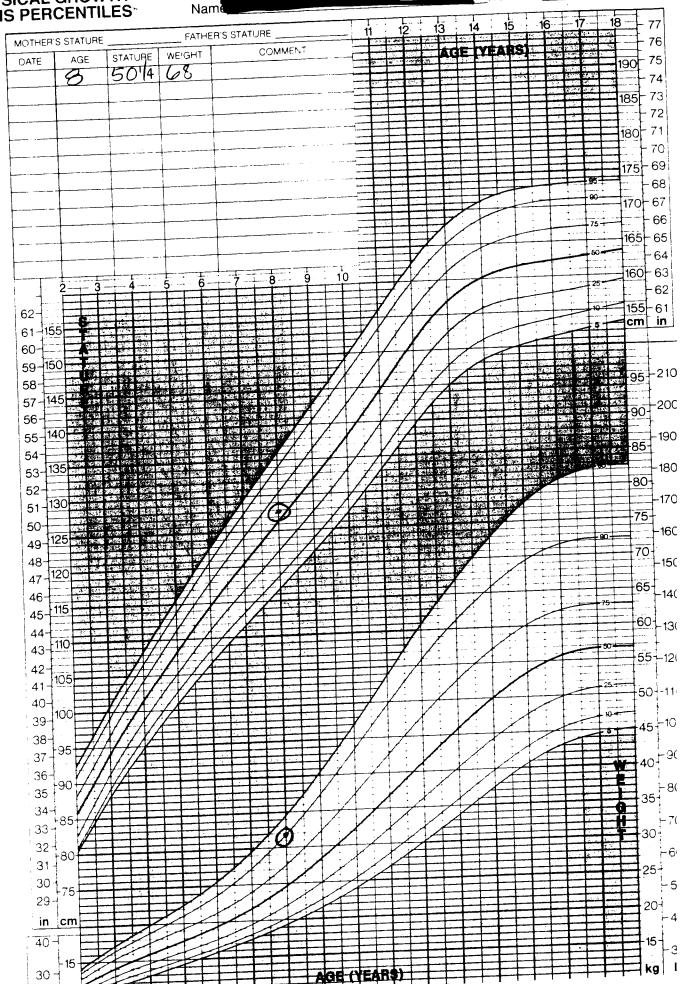
Pedialyte^{*}

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1982 Ross Products Division, Abbott Laboratories

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<u>PEDIATRIC</u> <u>PROBLEM LIST</u>

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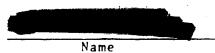


Adult Physical Assessment

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Bay Clinic WELL-CHILD RECORD SYSTEM Community Health Center Family Health Center . 9 - 11 Years Name ' Age In years Addressed/WNL Abnormal/See Comments Not Addressed Key Family Checks (Continued). V Temperament 22. Family interactions 48. Describe child's mood/affect 23. Sibling problems . Hyperactive 4. Physical activity 25. Tobacco use; alcohol/drug abuse 5. Problem habits Physical Examination Assessment 7. Sleeping...... 27. HT 50 1/4 8. Other_ 28. BP 92-154 29. Temp 974 Screening/immunizations 50. Remain alert for vision and Nutrition hearing problems 📮 32. Head 33. Eyes..... Plan/Anticipatory Quidance 34. Fundi 51. Plan_ 11. Eating habits 12. Favorite foods 36. Nose 52. Read daily Development 37. Oropharynx 🖸 - 53. Physical/sexual abuse concerns 13. Behavior 39. Neck 55. TV monitoring, 14. Best friend 40. Lungs..... 📮 alert to deceptive ads 16. Hobbies/sports... 41. Heart 56. Nutrition advice, snacks. 42. Abdomen..... 🖳 breakfast qd 18. School work 📈 43. Genitalia/..../ 57. Safety: bike, car, guns. outdoor, water 44. Tanner stage_ ly Family Checks 58. Dental hygiene, exams 45. Back/scoliosis..... 19. Marital changes Parent 59. Exercise, regular bedtimes 46. Musculoskeletat..... 20. Recent move ... 6 97 60. Parenting: rules, respect. communication 🗗 61. Home responsibilities, allowance Detail all abnormal findings below. Use reference numbers. a while Mother lau lau

Physician signature ______ RTO in _____ years See written progress note [





BOYS: 2 TO 18 YEARS PHYSICAL GROWTH NCHS PERCENTILES

Record #

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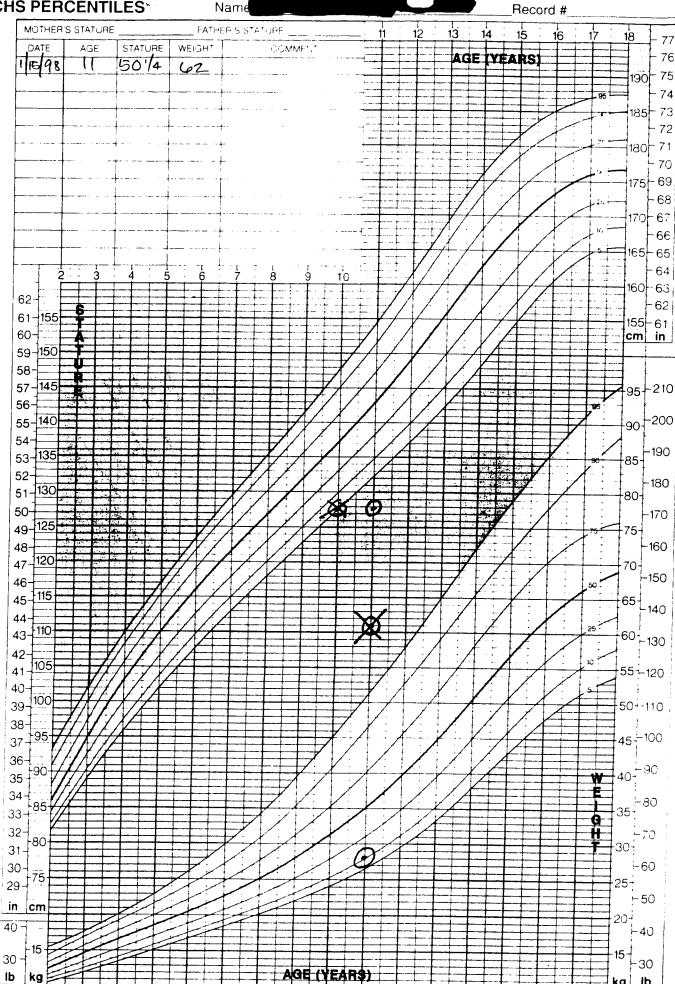
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Ross Products Division.

AUDIOSCOPE SCREENING RESULTS 20dBHL 725dBHL . 40dB HL Patient Tested by Y = Response N = No response Right Ear Left Ear 500 1000 2000 Frequency (Hz)

PUPIL'S HEALTH RECORD School (Pre-School) Name (Middle Initial) (Elementary) _ Address (Intermediate) ___ (High) _ Birth Date Health Insurance HM SA - QUEST PHYSICIAN'S EXAMINATION CODE: N-NORMAL; A-ABNORMAL; C-CORRECTED; R-RECEIVING CARE Orthopedic NAME AND SIGNATURE SIGNIFICANT FINDINGS AND RECOMMENDATIONS Scotlosis (Print Name on Elaborate back of card if necessary. If none, so state. Dash Line) SURVEYS IMMUNIZATION DATES (Month, Day, Year Required) SIGNIFICANT HISTORY Year mm Allergy (Type) Hib Tuberculin DTP Diabetes HepB **Epilepsy** Follow-up x-ray Rheumatic Fever DT Tuberculosis Td Surgery Urine **Heart Disease** Polio Communicable Disease Hgb. MMR Chickenpox Pertussis SCHOOL DATA **HEARING TESTING** DENTAL **VISION TESTING** Code Date Comments Grade Code Comments Date Comments 22 22 50'A 62 1/15/95



STATE OF HAWAII

DEPARTMENT OF EDUCATION
KAUMANA SCHOOL
1710 KAUMANA DRIVE
HILO, HAWAII 96720

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From KAUMANA ELEMENTARY SCHOOL	FAX NIIMBER
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de level ttack skills effectively v rally nderstanding v nderstandin	54	STEAKING
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ectively V V		Heads with understanding
vel Skills effectively	1	Reads well orally
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	Grade	READING

PROGRESS IN CLASSWORK	-	~	ယ	_	Year
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Dartinant	Ō	C	L		
rariscipates in physical activities	<	<			
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Other	1	_	L	L.	
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The state of the s	<	<u> </u>	_	_	

TEACHER'S COMMENTS:

Second Quarter

98

Constitution of the consti		_	_
Demonstrates awareness of safety rules and regulations	寸	\[\]	
Other:	1	~	L
OTHER AREAS Spelling	2	2	-
1 0	(-
		\exists	
PERSONAL & SOCIAL ATTITUDES	37)	4	
Is developing self-confidence	2		-
Uses suggestions and corrections effectively	<,	<u> </u>	
Respects rights and opinions of others	7	1	
Participates effectively within a group	7		1
Shows respect for property	7		1.
Shows respect for authority	$\stackrel{\scriptstyle \scriptstyle \times}{}$	+ *	
Other	1	-	Д.
WORK HABITS	7	₽) -	+
Does homework	5 (7	+
Works in an organized and orderly manner	< <u> </u>	\\ 	1_
Assumes and carries out responsibilities	<u>}</u>	7	_ _
Makes apprepriate use of time and materials	S :	1	
Demonstrates perseverance	$\sum_{i=1}^{n}$	7	_1
			-

Third Quarter

Fourth Quarter

ATTENDANCE	_	2	۵,		
ays Present	96	1		•	
ys Absent	۲۰	0			
mes Tardy	0				

Distribution: WHITE (Original) - School Copy, CANARY - Student Copy

Assigned to Grade....

. next year

	PROGRESS IN CLASSWORK			2	¢ J	_	Year
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Other	3113	1	5				
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			1	रो	Assumes and carries out responsibilities	Assumes a
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Fourth Quarter				\$		Does homework
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Third Quarter				_		
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Distribution:	
Distribution: WHITE (Original) - School Copy, CANARY - Student Copy	
CANARY - Student Copy	

Times Tardy Days Absent Days Present

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005

ATTENDANCE

40

TEACHER'S COMMENTS:

Forent Conference

Second Quarter

Third Quarter

Assigned to Grade... _ next year

CONSENT TO RELEASE OF INFORMATION <u>TO</u> THE DEPARTMENT OF HUMAN SERVICES, FAMILY AND ADULT SERVICES DIVISION

I,	hereby give my permission to
(2) Individual/agency or organization	to give the following information
in their records about me and/or my family and/or m	y ward [check as appropriate] to the DEPARTMENT OF
HUMAN SERVICES, FAMILY AND ADULT SERVICES DIVISION	ON.
The information to be reviewed/released is limited to the following: (3) Lecture of Charles of Cha	the course
This information is to be used for	(4) State purpose
(5) Check one of the following: [regulations governing Confidentiality of Alcohol and e disclosed without my written consent unless otherwise revoke this consent at any time execpt to the extent that this consent expires automatically one year from the ized herein is to enable the service providers to facilitate
1	
. Shakene	X 1-9-98
(7) Signature of applicant/recipient/legal guardian	Date
POBX 10142 Hile HT 9672	
(8) Address of applicant/recipient	Social Security No. or Birthdate of Applicant/Recipient

Complete two (2) copies:

Original - Individual/agency, Copy - Case record

Fax

□ Urgent	☐ For Review	☐ Please Comment	☐ Please Reply	☐ Please Recycle
Re:			///	
Phone: 94	9-7798	Date:	02/28/98	
Fax: 96	1-3202	Page	s: 2	
To: ATV	/	Fron		(CPS)

e WARNING: This message is intended only for the use of the individual to which it is addressed and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error please notify us immediately by telephone, and return the original to us at the above address.

1/1

FEBRUARY 5, 1998 F-48921

HAWATI COUNTY POLICE DEFARTMENT JUVENILE AID SECTION LIEUTENANT RONALD NAKAMICHI PHONE: 961-2327

MEDIA RELEASE CORRECTION

Big Island police are looking for a six-year-old boy who has been missing from his parent's custody in Hilo Since September 1997. He is Peter Kema Jr.

Peter is described as being of Filipino and Hawaiian descent; being about four feet tall; weighing between 45 and 50 pounds; and having black hair cut short except for the top front and back of the neck; and having brown eyes.

The boy was last seen by his mother in mid August 1997 when he accompanied his father to Honolulu. Peter's father last saw the boy in Honolulu in mid September 1997 when he turned custody of the child over to a relative known to him only as "Aunty Rose" -- whom he thought was named "Rose Makuakane" - of a Halawa address on Oahu. The father said he left his son with the woman at her lei stand at A'ala Park in downtown Honolulu.

Neither Peter nor "Rose" have been seen since.

Anyone with information about the whereabouts of Peter or Rose is asked to call Detective Glenn Nojiri of the Juvenile Aid Section at 961-2327 or the police emergency telephone number at 935-3311.

Those who wish to remain anonymous may call Crime Stoppers
DEPARTMENT OF HUMAN SERVICES SOCIAL SETHICES DIVISION at 961-8300 in Hilo or 329-8181 in Kona.

MAR 0 4 1998





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DEPARTMENT OF HUMAN SERVICES
SOCIAL SUNICES ENVISION

MAR 0 4 1998

EH INTAKE/ASSESSMENT UNIT HILO, HI 96720



- 122

CONSENT TO RELEASE OF INFORMATION TO THE DEPARTMENT OF HUMAN SERVICES, FAMILY AND ADULT SERVICES DIVISION

. Tolin Maureen Kom	hereby give my permission to
(1) Name of applicant/recipient/legal guardian (Aco)	
Bry Medical Clime	to give the following information
(2) Individual/agency or organization	
in their records about fine and/or fmy family and/or my ward [che	ck as appropriate] to the DEPARTMENT OF
HUMAN SERVICES, FAMILY AND ADULT SERVICES DIVISION.	
The information to be reviewed/released is limited to the following:	Peter In- may 1
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State - work date? Lost w	ed Hant mad nor
Dis / CPe A	7
This information is to be used for	(4) State purpose
(5) Check one of the following: [exceed 90 days from date signed); OR
[] FOR RESIDENTS OF DRUG AND ALCOHOLIC TREATMENT CEN I understand that my records are protected under the federal regulations. Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed provided for in the regulations. I also understand that I may revoke this action has been taken in reliance on it, and that in any event this consendate on which I sign this consent.	s governing Confidentiality of Alcohol and without my written consent unless otherwise s consent at any time execpt to the extent that
I further understand that the purpose of the disclosure authorized herein assessment and treatment. I authorize the DHS to redisclose the information of the disclosure authorized herein assessment and treatment.	n is to enable the service providers to facilitate nation to the following service provider:
l	
(7) Signature of applicant recipiers/legal guardian	<u> </u>
Y PU-BX 10742, 1416, 47 96721	Social Security No. or Birthdale
(2) Address of applicant recipient	of Applicant/Recipient

Complete two (2) copies:

Original - Individual/agency, Copy - Case record

DE 1:45 (6/-4)

Fax

To: Bay	Clinie 1-4795	From		CPS)
Fax: 961	1-4795	Page	s: 3	
Phone: 96	9-1427	Date:	02/25/98	
Re:				
☐ Urgent	☐ For Review	☐ Please Comment	☐ Please Reply	☐ Please Recycle

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Department of Human Services MILY AND ADULT SERVICES DI

INFORMATION AND REFERRAL FORM (For Communication between Units)

		3/	with Kema crss# 10786
			Case Name County Code Category and Case Number
T):	_	536/01 Jaylon Kema
			Name of Person
Fı	om:	_	Kithou & Lot 24 Nanawale Estates
		•	Address
			P.O. Box 10742, Hilo, HI 96721
1.	St	ate	request or information to be provided 2 and the last the
	_	. 2.	request or information to be provided Report accepted for physical chase ter fr. by his father.
		<u>) 18</u>	ter of the tother.
2.	Fi	nanc	ial status
	a.	To	be completed by IM Unit:
			Family is receiving \$monthly, effective
			Family ineligible for financial assistance. Effective
		-,	Reason: Closed / Suspended / Because
			Juspendeu / / because
			Resources exceed standard of assistance by t
		3)	Resources exceed standard of assistance by \$
		3,	the state of the s
			a) Person never received assistance in a federal category
			b) Person last received assistance: during
	b.	To	
	U.	10	be completed by Service Unit for Food Stamp purposes. (Use additional sheets if necessary)
		1)	Family receiving \$ for
			Amount Service cost item
			effective
		- 1	Month Year
		2)	Fámily receiving \$ forService cost item
			effective Month Year
		3)	Family receiving \$ for
		- /	Amount Service cost item
			effective
			Month Year
3.	Rep1	ly n	eeded / Reply not needed / X/

1945 1459 (PW_12) (7/90)

7/11/an

Department of Human Service FAMILY AND ADULT SERVICES DIVISION

INFORMATION AND REFERRAL FORM (For Communication between Units)

	Jai	plin Kema		
	J	Case Name	County Code	Category and Case Number
TO:		53601	Same	
		Unit		Name of Person
From:		EICI	Box 10	142
		Unit		Address
			- Hilo a	
1. St	ate	request or information to	be provided CPS A	eferral rec'd alleging
b	Luc	ical abuse a Pet	oe provided C13 /C	efthat he a deleging
-	violo	ical abuse of Pet	5 g. by his for	ather reter or.
			, , ,	
2. Fi	nanc	ial status		
a.	To	be completed by IM Unit:		
	1)	Family is receiving \$	monthly, ef	ffective
	2)	Family ineligible for fin	nancial assistance. F	ffective
		Reason: Closed / /	Suspended //	Recause
		**************************************		Decad 36
		Resources exceed standard	of assistance by \$	
	3)	Resources exceed standard For families/individuals	of assistance by \$	gible for firencial
	3)	For families/individuals	receiving GA or ineli	gible for financial assistance.
	3)	For families/individuals a) Person <u>never</u> received	receiving GA or ineli assistance in a fede	ral category //
		For families/individuals a) Person never received b) Person last received	receiving GA or ineli dassistance in a fede assistance Federal Ca	ral category // during tegory Month Vear
b.		For families/individuals a) Person never received b) Person last received	receiving GA or ineli dassistance in a fede assistance Federal Ca	ral category // during tegory Month Vear
b.	То	For families/individuals a) Person never received b) Person last received be completed by Service Un	receiving GA or ineli dassistance in a fede assistance Federal Ca	ral category // during
b.		For families/individuals a) Person never received b) Person last received be completed by Service Un Family receiving \$	receiving GA or ineli d assistance in a fede assistance Federal Ca it for Food Stamp purp	ral category / / / during / / / tegory / Month Year poses. (Use additional sheets if necessary)
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CONSENT TO RELEASE OF INFORMATION TO THE DEPARTMENT OF HUMAN SERVICES, FAMILY AND ADULT SERVICES DIVISION

4 Jaylin M. Kima Pc	TW U Kema icans/recipiens/legal guarding	hereby give my permission
Christophu	Cet Brit	to give the following information
(msy or organization my family and/or my wa	ward [check as appropriate] to the DEPARTMENT OF
HUMAN SERVICES, FAMILY AND A		•
The information to be reviewed/released	is limited to the following:	
3)	referen	of and dotte
<i>\)</i>	More T	Theirnes
	<u>Aer</u>	hatten.
This information is to be used for	D#3	(4) State purpose
of Serve	/ len	medel
(5) Check one of the following:		
[] This consent is good until	(6) month/day/year	_ (not to exceed 90 days from date signed); OR
Drug Abuse Patient Records, 42 provided for in the regulations.	e protected under the federal reging. C.F.R. Part 2, and cannot be dis I also understand that I may reve on it, and that in any event this	NT CENTERS: gulations governing Confidentiality of Alcohol and isclosed without my written consent unless otherwise voke this consent at any time execpt to the extent that is consent expires automatically one year from the
I further understand that the pur assessment and treatment. I auti	pose of the disclosure authorized horize the DHS to redisclose the	ed herein is to enable the service providers to facilitate e information to the following service provider:
1		
		34/6/98
> maxima Vol	ter J. Kenna S	2 /X 50-
(7) Signature of applicant/recip	ions/legal guardian	Date
X P.O.Bx 10142, Hilo	H1 96721	Control Country No. 175 d Acr
(a) Assirem or applicable recipie		Social Security No. or Birthdete of Applicant/Recipient

Complete two (2) copies:

Original - Individual/agency, Copy - Case record

All comments of the second of

•

MIS-0614 (7/87)	Return	Signature	Action See me	Information	Discussion	Approval	Date:	To:	MEMORANI
					sign + left mage. since not home	Ma cla Him	Subject:	From:	MEMORANDUM/ROUTE FORM Department of Husan Services

•