

\_\_\_\_\_  
Name of Guardian

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
E-Mail Address

IN THE FAMILY COURT OF THE FIRST CIRCUIT

STATE OF HAWAI'I

In the Matter of the Guardianship of	)	Case No. _____
	)	
_____	)	INITIAL REPORT OF THE GUARDIAN(S)
(Full Legal Name)	)	OF A MINOR FOR PERIOD OF
	)	_____ TO _____;
A Minor,	)	NOTICE OF FILING OF INITIAL
Born on _____	)	REPORT
_____	)	Minor's Name: _____

**INITIAL REPORT OF THE GUARDIAN(S) OF A MINOR  
FOR PERIOD OF \_\_\_\_\_ TO \_\_\_\_\_**

Age of Minor: \_\_\_\_ Weight: \_\_\_\_ Height: \_\_\_\_

Picture: (Attach/paste a recent full body photograph taken within the last 30 days)

(Attach Photograph Here)



In accordance with the Americans with Disabilities Act, as amended, and other applicable state and federal laws, if you require reasonable accommodation for a disability, please contact the ADA Coordinator at the First Circuit Family Court office by telephone at (808) 954-8200, fax (808) 954-8308, or via email at [adarequest@courts.hawaii.gov](mailto:adarequest@courts.hawaii.gov) at least ten (10) working days prior to your hearing or appointment date.

*Please call the Family Court Service Center at (808) 954-8290 if you have any questions regarding forms or procedures.*

**1. INFORMATION ON GUARDIAN(S)**

a. \_\_\_\_\_  
Guardian's Name Date Appointed

\_\_\_\_\_

Residence Address, City, State, Zip Code

\_\_\_\_\_

Mailing Address, City, State, Zip Code

\_\_\_\_\_

Telephone Number E-mail Address

b. \_\_\_\_\_  
Guardian's Name Date Appointed

\_\_\_\_\_

Residence Address, City, State, Zip Code

\_\_\_\_\_

Mailing Address, City, State, Zip Code

\_\_\_\_\_

Telephone Number E-mail Address

**2. RESIDENTIAL ADDRESS OF MINOR** (During the period covered by this Initial Report)

\_\_\_\_\_

Minor's Residence Address, City, State, Zip Code Telephone Number

\_\_\_\_\_

Caregiver's Name Telephone Number E-Mail Address

a. Home, Apartment, or other (if other please explain):

b. Describe Minor's sleeping arrangements (e.g., own bedroom, share room):

**3. PRIMARY CARE PHYSICIAN** (During the period covered by this Initial Report)

---

Doctor's Name, Address, City, State, Zip Code

Telephone Number

a. Date of Last Physical: \_\_\_\_\_

b. Dates of Appointments: \_\_\_\_\_

c. Describe the Reason for Each Doctor's Visit: (Attach additional pages if necessary)

d. Statement of Minor's Current Physical Health, and include any injuries or illnesses during this reporting period: (Attach additional pages if necessary)

**4. HOSPITALIZATIONS, URGENT CARE, AND EMERGENCY ROOM VISITS**

a. Date of hospitalizations (During this Reporting Period): \_\_\_\_\_

b. Which hospital, and reason for the hospitalization:

c. Dates of urgent care visits (During this Reporting Period): \_\_\_\_\_

d. Which urgent care, and the reason for the visit:

e. Dates of emergency room visits (During this Reporting Period): \_\_\_\_\_

f. Which emergency room, and the reason for the visit:

**5. MENTAL HEALTH CARE PROVIDERS** (During the period covered by this Initial Report)

a. Psychiatrist or Psychologist

\_\_\_\_\_  
Doctor's Name, Address, City, State, Zip Code Telephone Number

i. Date of Appointments: \_\_\_\_\_

ii. Reason for visits, and diagnosis, if any: (Attach additional pages if necessary)

b. Therapist

\_\_\_\_\_  
Therapist's Name, Address, City, State, Zip Code Telephone Number

i. Date of Appointments: \_\_\_\_\_

ii. Reason for visits, and diagnosis, if any: (Attach additional pages if necessary)

c. Statement of Minor's Current Mental Health: (Attach additional pages if necessary)

**6. DENTAL APPOINTMENTS** (During the period covered by this Initial Report)

\_\_\_\_\_  
Doctor's Name, Address, City, State, Zip Code Telephone Number

a. Date of Last Dental Appointment: \_\_\_\_\_

b. Date of Appointments: \_\_\_\_\_

c. Describe the Reason for Dental Visit: (Attach additional pages if necessary)

d. Statement of Minor's Current Dental Health: (Attach additional pages if necessary)

**7. VISION APPOINTMENTS** (During the period covered by this Initial Report)

\_\_\_\_\_  
Doctor's Name, Address, City, State, Zip Code Telephone Number

\_\_\_\_\_  
Doctor's Name, Address, City, State, Zip Code Telephone Number

a. Date of Last Vision Appointment: \_\_\_\_\_

b. Date of Appointments: \_\_\_\_\_

c. Describe the Reason for Vision Appointment: (Attach additional pages if necessary)

d. Statement of Minor's Current Vision: (Attach additional pages if necessary)

**8. MEDICAL DENTAL, AND VISION INSURANCE**

(Attach copy of Insurance Card)

**9. EDUCATION** (During the period covered by this Initial Report)

School Name, Address, City, State, Zip Code	Telephone Number
School Name, Address, City, State, Zip Code	Telephone Number

- a. Current Grade Level: \_\_\_\_\_
- b. Last date attended school: \_\_\_\_\_
- c. School Grades: (Attach most recent report card): \_\_\_\_\_
- d. Is minor home-schooled: \_\_\_ Yes \_\_\_ No (If the answer is "yes", please attach a copy of the initial report of the child's progress pursuant to HAR 8-12-18(b), and answer question i. and ii below; and if the answer is "no" please proceed to question 9e.)
  - i. Describe when minor began home-schooling, the reason(s) for minor being home-schooled, and the basic curriculum being followed:
  
  - ii. Describe any in-person contacts or visits from the Department of Education personnel:
- e. Does Minor have an Individual Education Plan: \_\_\_ Yes \_\_\_ No (If yes, please attach).
- f. Does Minor have a 504 Plan: \_\_\_ Yes \_\_\_ No (If yes, please attach).

g. Statement of Minor's progress in school: (Attach additional pages if necessary)

h. Describe Minor's extracurricular activities:

**10. CONTACT WITH DEPARTMENT OF HUMAN SERVICES** (During the period covered by this Initial Report)

a. Date of Contacts: \_\_\_\_\_

b. Social Worker: \_\_\_\_\_  
(Social Worker Name) Telephone Number

c. Describe the Reason for Contact or Visit: (Attach additional pages if necessary)

**11. Please include any additional information you believe is relevant to this Initial Report.**





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STATE OF HAWAI'I

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_____	)	INITIAL REPORT OF THE GUARDIAN(S)
(Full Legal Name)	)	OF A MINOR FOR PERIOD OF
	)	_____ TO _____;
A Minor,	)	NOTICE OF FILING OF INITIAL
	)	REPORT
Born on _____	)	
_____	)	Minor's Name:
	)	_____

**NOTICE OF FILING OF INITIAL REPORT OF THE GUARDIAN(S) OF A MINOR**

STATE OF HAWAI'I

TO:

Name and Address: (DHS Required)

**Department of Human Services**

**Child Welfare Services**

Name and Address:

_____	_____
_____	_____
_____	_____

Name and Address:

Name and Address:

_____	_____
_____	_____
_____	_____

Notice is hereby given that the above guardian(s) have submitted the attached Initial Report to the Family Court of the First Circuit and that copies will be forwarded to the above-named person(s) no later than fourteen (14) days after the date noted below.

DATED: Kapolei, Hawai'i, \_\_\_\_\_.

\_\_\_\_\_  
Guardian's Signature

\_\_\_\_\_  
Date