# State of Connecticut Department of Education Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child’s health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant or the school medical advisor prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or

every year for students participating on sports teams.10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required

*Please print*

Student Name (Last, First, Middle)

Birth Date

❑

Male

❑

Female

Address (Street, Town and ZIP code)

|  |  |  |
| --- | --- | --- |
| Parent/Guardian Name (Last, First, Middle) | Home Phone | Cell Phone |
| School/Grade | Race/Ethnicity  ❑ American Indian/ Alaskan Native  ❑ Hispanic/Latino | ❑ Black, not of Hispanic origin  ❑ White, not of Hispanic origin  ❑ Asian/Pacific Islander  ❑ Other |
| Primary Care Provider |

Health Insurance Company/Number\* or Medicaid/Number\*

Does your child have health insurance? Y NDoes your child have dental insurance? Y N If your child does not have health insurance, call **1-877-CT-HUSKY**

\* If applicable

**Part I — To be completed by parent/guardian.**

**Please answer these health history questions about your child before the physical examination.**

Please circle **Y** if “yes” or **N** if “no.” Explain all “yes” answers in the space provided below.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Any health concerns Y N | | | Hospitalization or Emergency Room visit Y | | N | Concussion | Y | N |
| Allergies to food or bee stings | Y | N | Any broken bones or dislocations Y | | N | Fainting or blacking out | Y | N |
| Allergies to medication | Y | N | Any muscle or joint injuries | Y | N | Chest pain | Y | N |
| Any other allergies | Y | N | Any neck or back injuries | Y | N | Heart problems | Y | N |
| Any daily medications | Y | N | Problems running | Y | N | High blood pressure | Y | N |
| Any problems with vision | Y | N | “Mono” (past 1 year) | Y | N | Bleeding more than expected | Y | N |
| Uses contacts or glasses | Y | N | Has only 1 kidney or testicle | Y | N | Problems breathing or coughing | Y | N |
| Any problems hearing | Y | N | Excessive weight gain/loss | Y | N | Any smoking | Y | N |
| Any problems with speech | Y | N | Dental braces, caps, or bridges | Y | N | Asthma treatment (past 3 years) | Y | N |
| **Family History**  Any relative ever have a sudden unexplained death (less than 50 years old) Y N | | | | | | Seizure treatment (past 2 years) | Y | N |
| Diabetes | Y | N |
| Any immediate family members have high cholesterol Y N | | | | | | ADHD/ADD | Y | N |

Please explain all “yes” answers here. For illnesses/injuries/etc., include the year and/or your child’s age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate* ***Medication Authorization Form*** *signed by a health care provider and parent/guardian.*

|  |
| --- |
| I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential  use in meeting my child’s health and educational needs in school. Signature of Parent/Guardian Date |

HAR-3 REV. 4/2010 **To be maintained in the student’s Cumulative School Health Record**

**Part II — Medical Evaluation** HAR-3 REV. 4/2010

**Health Care Provider must complete and sign the medical evaluation and physical examination**

Student Name Birth Date Date of Exam

❑ I have reviewed the health history information provided in Part I of this form

# Physical Exam

**Note:** \*Mandated Screening/Test to be completed by provider under Connecticut State Law

\***Height** \_\_\_\_\_ in. / \_\_\_\_\_% \***Weight** \_\_\_\_\_ lbs. / \_\_\_\_\_% **BMI** \_\_\_\_\_ / \_\_\_\_\_% **Pulse** \_\_\_\_\_ \***Blood Pressure** \_\_\_\_\_ / \_\_\_\_\_

Normal Describe Abnormal Ortho Normal Describe Abnormal

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Neurologic |  |  | Neck |  |  |
| HEENT |  | Shoulders |  |
| \*Gross Dental |  | Arms/Hands |  |
| Lymphatic |  | Hips |  |
| Heart |  | Knees |  |
| Lungs |  | Feet/Ankles |  |
| Abdomen |  | \***Postural** ❑ No sp abnor | inal ❑ Spine abnormality:  mality ❑ Mild ❑ Moderate  ❑ Marked ❑ Referral made | |
| Genitalia/ hernia |  |
| Skin |  |

# Screenings

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \***Vision Screening**  Type:  With glasses | Right Left  20/ 20/ | \***Auditory Screening**  Type: Right Left  ❑ Pass ❑ Pass  ❑ Fail ❑ Fail  ❑ Referral made | Lead: | Date |
|  |
| \***HCT/HGB:** |  |
| Without glasses ❑ Referral made | 20/ 20/ |
| Other: |  |

**TB:** High-risk group? ❑ No ❑ Yes PPD date read: Results: Treatment:

# \*IMMUNIZATIONS

❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED** \***Chronic Disease Assessment:**

**Asthma** ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced

*If yes, please provide a copy of the* ***Asthma Action Plan*** *to School*

**Anaphylaxis** ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source

**Allergies** *If yes, please provide a copy of the* ***Emergency Allergy Plan*** *to School*

History of Anaphylaxis ❑ No ❑ Yes Epi Pen required ❑ No ❑ Yes  **Diabetes** ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease: Seizures** ❑ No ❑ Yes, type:

❑ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.

*Explain:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daily Medications (*specify*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This student may: ❑ **participate fully in the school program**

❑ participate in the school program with the following restriction/adaptation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ This student may: ❑ **participate fully in athletic activities and competitive sports**

❑ participate in athletic activities and competitive sports with the following restriction/adaptation: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Yes ❑ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.

Is this the student’s medical home? ❑ Yes ❑ No ❑ I would like to discuss information in this report with the school nurse.

|  |
| --- |
| Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number |

# Immunization Record HAR-3 REV. 4/2010

**To the Health Care Provider: Please complete and initial below.**

**Vaccine (Month/Day/Year)** Note: \*Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
| **DTP/DTaP** | **\*** | **\*** | **\*** | **\*** |  |  |
| **DT/Td** |  |  |  |  |  |  |
| **Tdap** |  |  |  |  |  |  |
| **IPV/OPV** | **\*** | **\*** | **\*** |  |  |  |
| **MMR** |  |  |  |  |  |  |
| **Measles** | **\*** | **\*** |  |  |  |  |
| **Mumps** | **\*** |  |  |  |  |  |
| **Rubella** | **\*** |  |  |  |  |  |
| **HIB** | **\*** |  |  |  | Students u | nder age 5 |
| **Hep A** |  |  |  |  |  |  |
| **Hep B** | **\*** | **\*** | **\*** |  |  |  |
| **Varicella** | **\*** |  |  |  |  |  |
| **PCV** |  |  |  |  | Pneumococcal c | onjugate vaccine |
| **Meningococcal** |  |  |  |  |  |  |
| **HPV** |  |  |  |  |  |  |
| **Flu** |  |  |  |  |  |  |
| **Other** |  |  |  |  |  |  |

**Dose 1 Dose 2 Dose 3 Dose 4 Dose 5 Dose 6**

**Disease Hx \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**of above** (Specify) (Date) (Confirmed by)

**Exemption**

**Religious \_\_\_\_\_ Medical: Permanent \_\_\_\_\_ Temporary \_\_\_\_\_ Date \_\_\_\_\_**

Recertify Date \_\_\_\_\_\_\_\_\_ Recertify Date \_\_\_\_\_\_\_\_\_ Recertify Date \_\_\_\_\_\_\_\_

**Immunization Requirements for Newly Enrolled Students at Connecticut Schools**

**KINDERGARTEN** DTaP: At least 4 doses. The last dose must be given on or after 4th birthday

|  |  |  |
| --- | --- | --- |
| Polio: At least 3 doses. The last dose must be given on or after 4th birthday | | |
|  | | MMR: 1 dose on or after the 1st birthday  ***Measles:*** Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose  Hib: Children less than 5 yrs of age need 1 dose at 12 months or older Children 5 and older do not need proof of Hib vaccination Hep B: 3 doses |
|  | | Varicella: 1 dose on or after the 1st birthday or verification of disease |
| **GRADES 1-6** | | DTaP /Td/Tdap: At least 4 doses. The last dose must be given on or after 4th birthday  Students who start the series at age 7 or older only need a total of 3 doses  Polio: At least 3 doses. The last dose must be given on or after 4th birthday  MMR: 1 dose on or after the 1st birthday  ***Measles:*** Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose  Hep B: 3 doses |
|  | | Varicella: 1 dose on or after the 1st birthday or verification of disease |
| **GRADES 7-12** | | Td/Tdap: At least 3 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses  Polio: At least 3 doses. The last dose must be given on or after 4th birthday  MMR: 1 dose on or after the 1st birthday  ***Measles:*** Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose  Hep B: 3 doses |
|  | | Varicella: 1 dose on or after first birthday or verification of disease: |
|  | | **VARICELLA VACCINE:** For students <13 years of age, 1 dose given on or after the 1st birthday. For students 13 years of age or older, 2 doses given at least 4 weeks apart  **VERIFICATION OF DISEASE:** Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history |
| Initial/Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number | | |