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, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base 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 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

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 N Does 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						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				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

To be maintained in the student's Cumulative School Health Record

Part II — Medical Evaluation

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 spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made		
Genitalia/ hernia					
Skin					

Screenings

***Vision Screening**			***Auditory Screening**			History of Lead level ≥ 5µg/dL ❑ No ❑ Yes	Date
Type:	Right	Left	Type:	Right	Left		
With glasses	20/	20/		❑ Pass	❑ Pass	***HCT/HGB:**	
Without glasses	20/	20/		❑ Fail	❑ Fail	***Speech** (school entry only)	
❑ Referral made			❑ Referral made			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

Student Name: _____ **Birth Date:** _____ HAR-3 REV. 4/2012

Immunization Record

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.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap	*				Required for 7th grade entry	
IPV/OPV	*	*	*			
MMR	*	*			Required K-12th grade	
Measles	*	*			Required K-12th grade	
Mumps	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*				PK and K (Students under age 5)	
Hep A	*	*			PK and K (born 1/1/2007 or later)	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			2 doses required for K & 7th grade as of 8/1/2011	
PCV	*				PK and K (born 1/1/2007 or later)	
Meningococcal	*				Required for 7th grade entry	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

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: 2 doses given at least 28 day apart – 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after 1st birthday (Children 5 years and older do not need proof of Hib vaccination).
- Pneumococcal: 1 dose on or after 1st birthday (born 1/1/2007 or later and less than 5 years old).
- Hep A: 2 doses given six months apart-1st dose on or after 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: For students enrolled before August 1, 2011, 1 dose given on or after 1st birthday; for students enrolled on or after August 1, 2011 2 doses given 3 months apart – 1st dose on or after 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 of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart-1st dose on or after the 1st birthday.
- Hep B: 3 doses – the last dose on or after 24 weeks of age.
- Varicella: 1 dose on or after the 1st birthday or verification of disease*.

GRADE 7

- Tdap/Td: 1 dose of Tdap for students 11 yrs. or older enrolled in 7th grade who completed their primary DTaP series; For those students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are needed, one of which **must** be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart – 1st dose on or after the 1st birthday.
- Meningococcal: one dose for students enrolled in 7th grade.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: 2 doses given 3 months apart – 1st dose on or after 1st birthday or verification of disease*.

GRADES 8-12

- Td: At least 3 doses. Students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine one of which should be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart-1st dose on or after the 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: 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 or verification of disease*.

* **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.

Note: The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nation-wide shortage of supply for such vaccine.

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

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	❑ Male ❑ Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	**Visual Screening**	**Normal**	**Referral Made:**
Completed by: ❑ Dentist	Completed by: ❑ MD/DO ❑ APRN ❑ PA ❑ Dental Hygienist	❑ Yes ❑ Abnormal (Describe) _____ _____ _____ _____ _____	❑ Yes ❑ No

Risk Assessment	**Describe Risk Factors**	
❑ Low ❑ Moderate ❑ High	❑ Dental or orthodontic appliance ❑ Saliva ❑ Gingival condition ❑ Visible plaque ❑ Tooth demineralization ❑ Other _____	❑ Carious lesions ❑ Restorations ❑ Pain ❑ Swelling ❑ Trauma ❑ Other _____

Recommendation(s) by health care provider: _____

_____

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_____

Signature of Parent/Guardian Date

_____

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