



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 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

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 physi-

cian 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 | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Address (Street, Town and ZIP code) | | | |
| Parent/Guardian Name (Last, First, Middle) | | Home Phone | Cell Phone |
| School/Grade | Race/Ethnicity | | <input type="checkbox"/> Black, not of Hispanic origin |
| Primary Care Provider | <input type="checkbox"/> American Indian/ Alaskan Native | | <input type="checkbox"/> White, not of Hispanic origin |
| | <input type="checkbox"/> Hispanic/Latino | | <input type="checkbox"/> Asian/Pacific Islander |
| | | | <input type="checkbox"/> Other |
| Health Insurance Company/Number* or Medicaid/Number* | | | |
| Does your child have health insurance? | | Y N | If your child does not have health insurance, call 1-877-CT-HUSKY |
| Does your child have dental insurance? | | Y N | |

* If applicable

Part 1 — 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

Part 2 — 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 1 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 <input type="checkbox"/> No spinal abnormality <input type="checkbox"/> Spine abnormality: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Referral made | | |
| Genitalia/ hernia | | | | | |
| Skin | | | | | |

Screenings

| *Vision Screening | *Auditory Screening | History of Lead level ≥ 5µg/dL <input type="checkbox"/> No <input type="checkbox"/> Yes | Date |
|---|--|--|------|
| Type: <u>Right</u> <u>Left</u> With glasses 20/ 20/ Without glasses 20/ 20/ <input type="checkbox"/> Referral made | Type: <u>Right</u> <u>Left</u> <input type="checkbox"/> Pass <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Fail <input type="checkbox"/> Referral made | *HCT/HGB: | |
| | | *Speech (school entry only) | |
| | | 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 |
|---|-------------|---|

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 | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Home Address | | |
| Parent/Guardian Name (Last, First, Middle) | Home Phone | Cell Phone |

| | | | |
|--|--|--|--|
| Dental Examination Completed by: <input type="checkbox"/> Dentist | Visual Screening Completed by: <input type="checkbox"/> MD/DO <input type="checkbox"/> APRN <input type="checkbox"/> PA <input type="checkbox"/> Dental Hygienist | Normal <input type="checkbox"/> Yes <input type="checkbox"/> Abnormal (Describe) _____ _____ _____ _____ | Referral Made: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Risk Assessment | Describe Risk Factors | | |
| <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High | <input type="checkbox"/> Dental or orthodontic appliance <input type="checkbox"/> Saliva <input type="checkbox"/> Gingival condition <input type="checkbox"/> Visible plaque <input type="checkbox"/> Tooth demineralization <input type="checkbox"/> Other _____ | <input type="checkbox"/> Carious lesions <input type="checkbox"/> Restorations <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____ | |

Recommendation(s) by health care provider: _____

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

| | | | |
|-----------------------------------|---------------------------------------|-------------|---|
| Signature of health care provider | DMD / DDS / MD / DO / APRN / PA / RDH | Date Signed | Printed/Stamped <i>Provider</i> Name and Phone Number |
|-----------------------------------|---------------------------------------|-------------|---|

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 7th-12th grade | |
| 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 | * | * | | | See below for specific grade requirement | |
| Hep B | * | * | * | | Required PK-12th grade | |
| Varicella | * | * | | | Required K-12th grade | |
| PCV | * | | | | PK and K (Students under age 5) | |
| Meningococcal | * | | | | Required 7th-12th grade | |
| 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:** _____
Renew Date: _____

**Religious exemption documentation is required upon school enrollment and then renewed at 7th grade entry.
 Medical exemptions that are temporary in nature must be renewed annually.**

Immunization Requirements for Newly Enrolled Students at Connecticut Schools (as of 8/1/17)

KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 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, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See “HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES” column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**

GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See “HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES” column at the right for more specific information on grade level and year required.

HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade
- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through 11th grade
- August 1, 2024: Pre-K through 12th grade

** **Verification of disease:** Confirmation in writing by an 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 nationwide shortage of supply for such vaccine.

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