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.

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.

<table>
<thead>
<tr>
<th>Health concerns</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies to food or bee stings</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Allergies to medication</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Any daily medications</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Any problems with vision</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Uses contacts or glasses</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Any problems hearing</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Any problems with speech</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Family History</td>
<td></td>
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<tr>
<td>Any relative ever have a sudden unexplained death (less than 50 years old)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Any immediate family members have high cholesterol</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

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 II — Medical Evaluation
Health Care Provider must complete and sign the medical evaluation and physical examination

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

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 _____ / _____

<table>
<thead>
<tr>
<th>Normal</th>
<th>Describe Abnormal</th>
<th>Ortho</th>
<th>Normal</th>
<th>Describe Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurologic</td>
<td></td>
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<tr>
<td>HEENT</td>
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<tr>
<td>*Gross Dental</td>
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<tr>
<td>Lymphatic</td>
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<tr>
<td>Heart</td>
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<tr>
<td>Lungs</td>
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<tr>
<td>Abdomen</td>
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<tr>
<td>Genitalia/ hernia</td>
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<tr>
<td>Skin</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Neck</td>
<td>No spinal abnormality</td>
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<tr>
<td>Shoulders</td>
<td></td>
<td></td>
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<tr>
<td>Arms/Hands</td>
<td></td>
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<tr>
<td>Hips</td>
<td>Membrane</td>
<td>Moderate</td>
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</tr>
<tr>
<td>Knees</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Feet/Ankles</td>
<td></td>
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</tbody>
</table>

Screenings

*Vision Screening

Type: Right  Left
With glasses 20/ 20/
Without glasses 20/ 20/

*Auditory Screening

Type: Right  Left
Pass  Pass
Fail  Fail

History of Lead level ≥ 5μg/dL  No  Yes

HCT/HGB:

*Speech (school entry only)

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

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.
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.

Disease Hx ________________________________     ________________________________      ________________________________
of above
(Specify) (Date) (Confirmed by)

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.

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• Meningococcal: 1 dose

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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.

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)

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

DTP/DTaP * * * * * 
DT/Td * 
Tdap * 
IPV/OPV * * * 
MMR * * 
Measles * * 
Mumps * * 
Rubella * * 
HIB * 
Hep A * * 
Hep B * * * 
Varicella * * 
PCV * 
Meningococcal * 
HPV 
Flu * 
Other PK students 24-59 months old – given annually

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

Student Name: ____________________________ Birth Date: ____________

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

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

DTP/DTaP * * * * * 
DT/Td * 
Tdap * 
IPV/OPV * * * 
MMR * * 
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