



# 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 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"/> American Indian/ Alaskan Native <input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> 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
<b>Family History</b>						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)						Diabetes	Y	N
Any immediate family members have high cholesterol						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.

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

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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**

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

**Screenings**

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