



# 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 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 <b>1-877-CT-HUSKY</b>
Does your child have dental insurance?		Y N	

\* 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)			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 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 <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	Lead:	Date
Type: <span style="margin-left: 40px;">Right</span> <span style="margin-left: 40px;">Left</span> With glasses <span style="margin-left: 40px;">20/</span> <span style="margin-left: 40px;">20/</span> Without glasses <span style="margin-left: 40px;">20/</span> <span style="margin-left: 40px;">20/</span> <input type="checkbox"/> Referral made	Type: <span style="margin-left: 40px;">Right</span> <span style="margin-left: 40px;">Left</span> <input type="checkbox"/> Pass <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Fail <input type="checkbox"/> Referral made	*HCT/HGB:	
		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 <i>Provider</i> Name and Phone Number
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# 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						
IPV/OPV	*	*	*			
MMR						
Measles	*	*				
Mumps	*					
Rubella	*					
HIB	*				Students under age 5	
Hep A						
Hep B	*	*	*			
Varicella	*					
PCV					Pneumococcal conjugate vaccine	
Meningococcal						
HPV						
Flu						
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: 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 <i>Provider</i> Name and Phone Number
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