

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 ☐ Male ☐ Female Birth Date Student Name (Last, First, Middle) Address (Street, Town and ZIP code) Cell Phone Home Phone Parent/Guardian Name (Last, First, Middle) ☐ Black, not of Hispanic origin Race/Ethnicity School/Grade ☐ White, not of Hispanic origin ☐ American Indian/ ☐ Asian/Pacific Islander Alaskan Native Primary Care Provider Other ☐ Hispanic/Latino Health Insurance Company/Number* or Medicaid/Number* Ν Does your child have health insurance? If your child does not have health insurance, call 1-877-CT-HUSKY N Does your child have dental insurance? * 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. Hospitalization or Emergency Room visit Y Concussion N Any health concerns Fainting or blacking out Y N N Any broken bones or dislocations Y Y N Allergies to food or bee stings Y N Y N Chest pain Any muscle or joint injuries Y N Allergies to medication Ν Y N Υ Heart problems Y N Any neck or back injuries Any other allergies Y N Y N High blood pressure Y N Problems running Any daily medications Y Ν Y N Bleeding more than expected Y N "Mono" (past 1 year) Any problems with vision N Has only 1 kidney or testicle Y N Problems breathing or coughing ¥ Y N Uses contacts or glasses Y N Y Ν Any smoking Excessive weight gain/loss Any problems hearing Y N Y N Ÿ N Dental braces, caps, or bridges Asthma treatment (past 3 years) Any problems with speech Seizure treatment (past 2 years) Y N Family History Y Ν Diabetes Any relative ever have a sudden unexplained death (less than 50 years old) Y Ν ADHD/ADD N N Any immediate family members have high cholesterol 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

Part II — Medical Evaluation

				gn the medical eva Birth Date			
☐ I have reviewed the he							
Physical Exam							
	ening/Test	to be comp	leted by provider	under Connecticut State	Law		
*Height in. /	% *\	Weight	lbs. /%	BMI/%	Pulse	*Blood Pressur	e/
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Screenings							
*Vision Screening			*Auditory Sc	reening			Date
Type:	Right	<u>Left</u>	Type:	Right Left	Lead:		
With glasses	20/	20/		□ Pass □ Pass	*HCT/	HGR:	
Without glasses	20/	20/		☐ Fail ☐ Fail	12027		
☐ Referral made			☐ Referral n	nade	Other:	Other:	
TB: High-risk group? ☐ No ☐ Yes		☐ Yes	PPD date read: Results:			Treatment:	
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☐ Up to Date or ☐ C	atch-up Sc	hedule: MU	ST HAVE IMM	UNIZATION RECORI) ATTACHED		
*Chronic Disease Ass							
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Anaphylaxis □ No	☐ Yes:	□ Food □	Insects 🗆 Latex	☐ Unknown source			
Allergies If yes, j	<i>please pro</i> v		of the Emergency No 🗀 Yes	Allergy Plan to School Epi Pen required	□ No □ Y	es	
Diabetes	^	☐ Type I		Other Chronic Dis	sease:		
Seizures 🗆 No	☐ Yes, ty	ype:					
☐ This student has a c	developme	ntal, emotic	nal, behavioral or	r psychiatric condition th	at may affect h	is or her education	onal experience.
Explain:							· · · · · · · · · · · · · · · · · · ·
This student may:	l participa I participat	te fully in the sch	the school program with	nm the following restriction/	/adaptation:		
This student may:) participa I participat	i te fully in a e in athletic	athletic activities activities activities and cor	and competitive sports mpetitive sports with the	following restr	iction/adaptation	
☐ Yes ☐ No Based o Is this the student's m	n this com edical hon	prehensive I ne? 🛭 Yes	nealth history and No I wo	physical examination, thull like to discuss inform	is student has n nation in this re	naintained his/her port with the sch	r level of wellness ool nurse.
Signature of health care pro	nvider MD	/ DO / APRN / P	A	Date Signed	Printed/Star	mped <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.

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HIEP A		*				O. 3. 4-					
Hep B		*				Students	under age 5				
Provided											
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Initial/Signature of health care provider MD / DO / APRN / PA