

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, aphysician 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	□ Male □ Female	
Address (Street, Town and ZIP code)			
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone	
School/Grade	Race/Ethnicity American Indian/	 Black, not of Hispanic origin White, not of Hispanic origin 	
Primary Care Provider	Alaskan Native	 Asian/Pacific Islander Other 	
Health Insurance Company/Number* or Medicaid/Number	*		

Does y	our	child	have	health	insurance?	Y	N
					insurance?		N

If your child does not have health insurance, call 1-877-CT-HUSKY

* 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	tΥ	N	Concussion	Y	Ν
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	Ν
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	Ν
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	Ν	Bleeding more than expected	Y	Ν
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	Ν	Problems breathing or coughing	Y	Ν
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	Ν
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	Ν
						Seizure treatment (past 2 years)	Y	N
Family History Any relative ever have a sudden	unexplai	ined de	ath (less than 50 years old)	Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol			Y	N	ADHD/ADD	Y	N	
					1/	1.11.15 (

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. Si

Signature of Parent/Guardian

Date

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name	
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Birth Date

Date of Exam

HAR-3 REV. 1/2022

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

*Heightin. /	% *Wei	ghtlbs. /%	BMI/% Pul	se	*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 🛛 No s	pinal	□ Spine abnormality:
Genitalia/ hernia			abno	rmality	□ Mild □ Moderate
Skin					Marked Referral made

Screenings

*Vision Screening	creening *Auditory Screening		Screening			History of Lead level	Date
Туре:	<u>Right</u>	Left	Type:	<u>Right</u>	Left	\geq 5µg/dL \Box No \Box Yes	
With glasses	20/	20/		D Pass	Pass	*HCT/HGB:	
Without glasses	20/	20/		🗅 Fail 🛛 Fail		*Speech (school entry only)	
Referral made			🗆 Referral 1	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:

DNO Ves: DIntermittent Mild Persistent Moderate Persistent Severe Persistent Exercise induced Asthma If yes, please provide a copy of the Asthma Action Plan to School

Anaphylaxis 🗆 No 🛛 🖸 Yes: 🗆 Food 🖵 Insects 🖵 Latex 🖵 Unknown source If yes, please provide a copy of the Emergency Allergy Plan to School Allergies □ Yes Epi Pen required **No** Yes History of Anaphylaxis 🛛 No

Other Chronic Disease: Diabetes □ No □ Yes: □ Type I □ Type II

□ No □ Yes, type: Seizures

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: D participate fully in the school program

participate in the school program with the following restriction/adaptation:

This student may: D participate fully in athletic activities and competitive sports D 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. I would like to discuss information in this report with the school nurse. Is this the student's medical home? \Box Yes \Box No

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	□ Male □ Female

Home Address

Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination Completed by: Dentist	Visual Screening Completed by: MD/DO APRN PA Dental Hygienist	Normal Yes Abnormal (Describe)	Referral Made: Yes No
Risk Assessment		Describe Risk I	Factors
□ Low □ Moderate □ High	 Dental or orthodom Saliva Gingival condition Visible plaque Tooth demineralization Other 	ation	 Carious lesions Restorations Pain Swelling Trauma Other

Recommendation(s) by health care provider:

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Signature of Parent/Guardian

Date

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 7	th-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 (Stud	ents under age 5)
Hep A	*	*			See below for speci	fie grade requirement
Hep B	*	*	*		Required P	K-12th grade
Varicella	*	*			Required	K-12th grade
PCV	*				PK and K (Stud	ents under age 5)
Meningococcal	*				Required	7th-12th grade
HPV						
Flu	*				PK students 24-59 mo	nths old – given annually
Other						

Disease Hx ____

of above

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(Date)

Medical Exemption:

(Confirmed by)

Religious Exemption: Religious exemptions must meet the criteria established in <u>Public Act 21-6</u>: <u>https://portal.ct.gov/-/media/SDE/Digest/2020-</u> 21/CSDE-Guidance---Immunizations.pdf.

(Specify)

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 the1st 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 the1st 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

Must have signed and completed medical exemption form attached.

Agencies/DPH/dph/infectious diseases/immunization/CT-WIZ/CT-

https://portal.ct.gov/-/media/Departments-and-

Medical-Exemption-Form-final-09272021 fillable3.pdf

- 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.