



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 | | |
| 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 |
| Family History | | | | | | Seizure treatment (past 2 years) | | |
| Any relative ever have a sudden unexplained death (less than 50 years old) | | | Y N | | | Diabetes | | |
| Any immediate family members have high cholesterol | | | Y N | | | ADHD/ADD | | |

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: Right Left | Type: Right Left | | | | |
| With glasses 20/ 20/ | <input type="checkbox"/> Pass <input type="checkbox"/> Fail | <input type="checkbox"/> Pass <input type="checkbox"/> Fail | | | |
| Without glasses 20/ 20/ | <input type="checkbox"/> Referral made | | *HCT/HGB: | | |
| <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 |
|---|-------------|--|

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 | | | | | | |
| 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 DTPaP: 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 DTPaP /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 |
|---|-------------|---|