



# 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) physician 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	
Primary Care Provider	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Other	
Does your child have health insurance? Y N	If you child does not have insurance, call 1-877-CT-HUSKY	
Does your child have dental insurance? Y N		
Health Insurance Company/Number* or Medicaid/Number*	*If applicable	

## Part 1 — To be completed by parent/guardian

**Please answer these health history questions about your child before the physical examination**

Any health concerns	Y N	Hospitalizations 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?		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 illness/injuries/etc. include the year and/or your child's age at the time:

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 2 — Medical Evaluation

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**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 1 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		<b>*Postural</b> <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 \* According to Bright Future's Periodicity Schedule

*Vision Screening	*Auditory Screening	*History of Lead Level ≥3.5 µg/dL <input type="checkbox"/> No <input type="checkbox"/> Yes	Date
Type: <u>Right</u> <u>Left</u> With glasses      20/      20/ Without glasses      20/      20/ <input type="checkbox"/> Referral made	Type: <u>Right</u> <u>Left</u> <input type="checkbox"/> Pass <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Fail <input type="checkbox"/> Referral made	Results: <input type="checkbox"/> Pass <input type="checkbox"/> Fail	
			*Speech (school entry only)
			*HCT/HGB:
<b>TB:</b> High-risk group? <input type="checkbox"/> No <input type="checkbox"/> 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

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**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	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

<b>Dental Examination</b> Completed by: <input type="checkbox"/> Dentist	<b>Visual Screening</b> Completed by: <input type="checkbox"/> MD/DO <input type="checkbox"/> APRN <input type="checkbox"/> PA <input type="checkbox"/> Dental Hygienist	<b>Normal</b> <input type="checkbox"/> Yes <input type="checkbox"/> Abnormal (Describe) _____ _____ _____ _____	<b>Referral Made:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Risk Assessment</b> <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	<b>Describe Risk Factors</b>		
	<input type="checkbox"/> Dental or orthodontic appliance <input type="checkbox"/> Saliva <input type="checkbox"/> Gingival condition <input type="checkbox"/> Visible plaque <input type="checkbox"/> Tooth demineralization <input type="checkbox"/> Other _____	<input type="checkbox"/> Carious lesions <input type="checkbox"/> Restorations <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____	

Recommendation(s) by health care provider: \_\_\_\_\_

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

Signature of health care provider	DMD / DDS / MD / DO / APRN / PA / RDH	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	*				Required 7th-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 (Students under age 5)	
Hep A	*	*			See below for specific grade requirement	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			Required K-12th grade	
PCV	*				PK and K (Students under age 5)	
Meningococcal	*				Required 7th-12th grade	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

Disease Hx \_\_\_\_\_

of above

(Specify) \_\_\_\_\_

(Date) \_\_\_\_\_

(Confirmed by) \_\_\_\_\_

**Religious Exemption:** \_\_\_\_\_

Religious exemptions must meet the criteria established in  
<https://portal.ct.gov/-/media/sde/digest/2020-21/csde-guidance---immunizations.pdf>

**Medical Exemption:** \_\_\_\_\_

Must have signed and completed medical exemption form attached.  
[https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious\\_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf](https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf)

**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 the 1st 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 the 1st 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**

- 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.

Initial/Signature of health care provider MD / DO / APRN / PA

Date Signed

Printed/Stamped **Provider** Name and Phone Number