# 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 assess- ment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, a physi-

cian 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 ❑ Black, not of Hispanic origin  ❑ A merican Indian/ ❑ White, not of Hispanic origin Alaskan Native ❑ Asian/Pacific Islander  ❑ Hispanic/Latino ❑ Other |
| Primary Care Provider |

Health Insurance Company/Number\* or Medicaid/Number\*

Does your child have health insurance? Y N Does your child have dental insurance? Y N

\* If applicable

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

## 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 | 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**  Any relative ever have a sudden unexplained death (less than 50 years old) | | | | Y | N | Seizure treatment (past 2 years) | 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

HAR-3 REV. 7/2018

##### To be maintained in the student’s Cumulative School Health Record

**Part 2 — Medical Evaluation**

HAR-3 REV. 7/2018

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

Student Name

❑ I have reviewed the health history information provided in Part 1 of this form

# Physical Exam

Birth Date

Date of 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** ❑ No spinal ❑ Spine abnormality: abnormality ❑ Mild ❑ Moderate  ❑ Marked ❑ Referral made | | |
| Genitalia/ hernia |  |
| Skin |  |

# Screenings

|  |  |  |  |
| --- | --- | --- | --- |
| \***Vision Screening**  Type: Right Left With glasses 20/ 20/ | \***Auditory Screening**  Type: Right Left  ❑ Pass ❑ Pass  ❑ Fail ❑ Fail  ❑ Referral made | History of Lead level  ≥ 5µg/dL ❑ No ❑ Yes | Date |
|  |
| \***HCT/HGB:** |  |
| Without glasses 20/ 20/  ❑ Referral made | \***Speech** (school entry only) |  |
| 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

# Part 3 — Oral Health Assessment/Screening

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## 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** | **Visual Screening** | **Normal** | **Referral Made:** |
| Completed by: | Completed by: | ❑ Yes | ❑ Yes |
| ❑ Dentist | ❑ MD/DO | ❑ Abnormal (Describe) | ❑ No |
|  | ❑ APRN |  |  |
|  | ❑ PA  ❑ Dental Hygienist |  |  |
| **Risk Assessment** | **Describe Risk Factors** | | |
| ❑ Low | ❑ Dental or orthodontic appliance | | ❑ Carious lesions |
| ❑ Moderate | ❑ Saliva | | ❑ Restorations |
| ❑ High | ❑ Gingival condition | | ❑ Pain |
|  | ❑ Visible plaque | | ❑ Swelling |
|  | ❑ Tooth demineralization | | ❑ Trauma |
|  | ❑ Other | | ❑ 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 ***Provider*** Name and Phone Number

#### Student Name:

**Birth Date:**

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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)

**Exemption:** Religious

**Medical:** Permanent

Temporary

**Date:**

**Renew Date:**

**Religious exemption documentation is required upon school enrollment and then renewed at 7th grade entry.**

**Medical exemptions that are temporary in nature must be renewed annually.**

### Immunization Requirements for Newly Enrolled Students at Connecticut Schools (as of 8/1/17)

**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 contain- ing 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