

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, 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 pr	int					
Student Name (Last, First, Middle)				Birth Date			☐ Male ☐ Fema	☐ Male ☐ Female	
Address (Street, Town and ZIP code	e)			<u> </u>			I		
Parent/Guardian Name (Last, First, Middle)					Pho	ne	Cell Phone		
School/Grade				Race/Ethnicity					
Primary Care Provider				Alaskan Native					
Health Insurance Company/Nu	ımber*	or M	edicaid/Number*						
Does your child have health in Does your child have dental in			H VOII	r child do	oes r	ot hav	ve health insurance, call 1-877-C	Γ-HUS	KY
Please cir	ealth	hist "yes	" or N if "no." Explain all "	t your	ch iwers	ild b	efore the physical exam		
Any health concerns	Y	N	Hospitalization or Emergency			N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or disloc		Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y Y	N	Any muscle or joint injuries	<u>s</u>	Y	N	Chest pain	Y	N
Any other allergies Any daily medications	Y	N	Any neck or back injuries		Y	N	Heart problems	Y	N
Any problems with vision	Y	N N	Problems running "Mono" (past 1 year)		Y	N N	High blood pressure	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicl		Y	N	Bleeding more than expected Problems breathing or coughing	Y	N 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 brid	oes .	Y	N	Asthma treatment (past 3 years)	Y	N
Family History				5-3			Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden t	ınexplaiı	ned 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
Please explain all "yes" answe				le the yea	r an	d/or y	our child's age at the time.		
Is there anything you want to o	liscuss	with t	he school nurse? Y N	If yes, ex	plaiı	1:			
Please list any medications yo child will need to take in school									
All medications taken in school re	quire a s	epara	te Medication Authorization 1	F orm sign	ed b	y a hea	lth care provider and parent/guardia	n.	
give permission for release and excha	nge of inf	ormati	on on this form						

Signature of Parent/Guardian

between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

HAR-3 REV. 7/2018 Part 2 — Medical Evaluation Health Care Provider must complete and sign the medical evaluation and physical examination Birth Date _____ Date of Exam Student Name ☐ 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 Neck Neurologic **HEENT** Shoulders Arms/Hands *Gross Dental Hips Lymphatic Heart Knees Lungs Feet/Ankles Abdomen *Postural ☐ No spinal □ Spine abnormality: Genitalia/ hernia abnormality ☐ Moderate ☐ Mild ☐ Marked ☐ Referral made Skin **Screenings** Date *Vision Screening *Auditory Screening History of Lead level $\geq 5\mu g/dL \square No \square Yes$ Right Type: Right **Left** Type: <u>Left</u> ☐ Pass □ Pass *HCT/HGB: With glasses 20/ 20/ ☐ Fail □ Fail Without glasses 20/ 20/ *Speech (school entry only) ■ Referral made Other: ☐ Referral made ☐ Yes PPD date read: **TB:** High-risk group? ☐ No Results: Treatment: *IMMUNIZATIONS ☐ Up to Date or ☐ Catch-up Schedule: MUST HAVE IMMUNIZATION RECORD ATTACHED *Chronic Disease Assessment: ☐ Yes: ☐ Intermittent ☐ 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** 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: \square participate fully in the school program aparticipate in the school program with the following restriction/adaptation: ☐ participate fully in athletic activities and competitive sports This student may: ☐ 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? \square Yes \square No \square I would like to discuss information in this report with the school nurse.

Date Signed

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

Printed/Stamped Provider Name and Phone Number

Printed/Stamped Provider Name and Phone Number

Part 3 — Oral Health Assessment/Screening Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

Signature of health care provider

DMD / DDS / MD / DO / APRN / PA / RDH

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, Mi	Birth Date		Date of Exam				
School	Grade		☐ Male ☐ Female				
Home Address			l		<u> </u>		
Parent/Guardian Name (La:	Home Phone		Cell Phone				
Dental Examination	Visual Screening	Normal		Referral Made:			
Completed by: ☐ Dentist	Completed by: MD/DO APRN PA Dental Hygienist	☐ Yes ☐ Abnormal (Describe)		☐ Yes ☐ No			
Risk Assessment		D	escribe Risk I	Factors			
☐ Low☐ Moderate☐ High	 □ Dental or orthodon □ Saliva □ Gingival condition □ Visible plaque □ Tooth demineraliza □ Other 	tion	_	☐ Carious lesion ☐ Restorations ☐ Pain ☐ Swelling ☐ Trauma ☐ Other	ns		
Recommendation(s) by hea	alth care provider:						
I give permission for release use in meeting my child's h			etween the scho	ool nurse and health	care provider for confidential		
Signature of Parent/Guar	rdian				Date		

Date Signed

Student Name:	Birth Date:	HAR-3 REV. 7/2018

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 (Stude	ents under age 5)
Нер А	*	*			See below for specif	ic grade requirement
Нер В	*	*	*		Required PI	K-12th grade
Varicella	*	*			Required	K-12th grade
PCV	*				PK and K (Stude	ents under age 5)
Meningococcal	*				Required 7	th-12th grade
HPV						
Flu	*				PK students 24-59 mon	ths old – given annually
Other						
Disease Hx _						
of above	(Specify)		(Date)	(Confirmed by)	
Exempt	ion: Religious	Medical	: Permanent	Temporary	Date:	
Renew I	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 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 <i>Provider</i> Name and Phone Number