State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth – 5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ❑ American Indian/Alaskan Native ❑ Hispanic/Latino ❑ Black, not of Hispanic origin ❑ Asian/Pacific Islander ❑ White, not of Hispanic origin ❑ Other	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance?	Y	N	If your child does not have health insurance, call **1-877-CT-HUSKY**
Does your child have dental insurance?	Y	N	
Does your child have HUSKY insurance?	Y	N	

* 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	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental examination in the last 6 months	Y	N	Any heart problems	Y	N
Any daily/ongoing medications	Y	N				Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place to another	Y	N	6. Interaction with others	Y	N	Eating concerns	Y	N
			7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

*All medications taken in child care programs require a separate **Medication Authorization Form** signed by an authorized prescriber and parent/guardian.*

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.	Signature of Parent/Guardian Date

Part II — Health Evaluation

To the Health Care Provider: Please complete all sections and sign. Explain any screenings required by age but not conducted.

Child's Name ______ Birth Date (mm/dd/yy) ______ Date of History/Physical Exam (mm/dd/yy) ______

LENGTH/HEIGHT		WEIGHT		WT FOR HT/BMI	HEAD CIRCUMFERENCE[1]		BLOOD PRESSURE[2]
IN/CM	%ILE	LB/KG	%ILE	%ILE	IN/CM	%ILE	/

Screening/Test Results

Screening Test	Result	Date	Abnormal/Comments
Vision[2] Test type:			
Hearing[3] Test type:			
Lead[4] Risk: Yes/No			
TB[4] Risk: Yes/No			
Urinalysis (UA)[4]			
Anemia[5] (HGB/HCT) Risk: Yes/No			
Developmental Assessment[6] Test type:			

Has this child received dental care in the last 12 months?[7] ❑ **Yes** ❑ **No** ❑ **N/A**

*** Chronic Disease Assessment:**

Yes	No		Date of onset
❑	❑	Asthma: ❑ mild ❑ moderate ❑ severe ❑ exercise induced ❑ unclassified	______
❑	❑	Diabetes: ❑ Type I ❑ Type II	______
❑	❑	Anaphylaxis: ❑ med. ❑ food ❑ insect ❑ latex	______
❑	❑	Seizures: Type ______	______
❑	❑	Other: Please specify ______	______

Minimum requirements: [1]Up to 2 years; [2]annual at 3 years; [3]annual at 4 years; [4]as needed; [5]9–12 months; [6]each visit through 5 years; [7]annual at 2–3 years. Federal requirements (eg, Head Start, WIC) may vary.
***Prior to Public School Entry: Same as above and Hgb/hct.**

Immunization Record

Vaccine (Month/Day/Year)

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP						
DTP/Hib						
DTaP						
DT/Td						
OPV						
IPV						
MMR						
Measles						
Mumps						
Rubella						
HIB						
Hep B						
Varicella						
PCV					Pneumococcal conjugate vaccine	

Other Vaccines (Specify)

Disease Hx of above ______ (Specify) ______ (Date mm/yy) ______ (Confirmed by)

Exemption

Religious _____ **Medical: Permanent** _____ **Temporary** _____ **Date** _____

Recertify Date ________ Recertify Date ________ Recertify Date ________

This child has the following problems which may adversely affect his or her educational experience:

❑ Vision ❑ Auditory ❑ Speech/Language ❑ Physical Dysfunction ❑ Emotional/Social ❑ Behavior

❑ The child has a health condition which may require intervention at the program, e.g., seizures, allergies, asthma, anaphylaxis, special diet, long-term medication. *Specify:* ______

❑ Yes ❑ No This child has a medical or emotional illness/disorder that now poses a risk to other children or affects the child's ability to participate safely in the program.

❑ Yes ❑ No Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.

❑ The child may fully participate in the program.

❑ The child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

❑ I would like to discuss information in this report with the early childhood provider and/or health consultant/coordinator.

Signature of health care provider (MD/DO NP PA)	Name (Please type or print.)	Phone number

Address:

❑ Yes ❑ No Is this the child's Medical Home? | Next Appointment (mm/yy): | Next Immunization Appointment (mm/yy):