## State of Connecticut

# Early Childhood Health Assessment Record

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 also be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunization and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse, a physician assistant or the school medical advisor prior to entering an early childhood program in Connecticut.

*Please print*

| Name of Child (Last, First, Middle) | Social Security Number | Birth Date | Sex |
|---|---|---|---|
| | | | |

| Address (Street)<br><br>(Town and ZIP code) | Race/Ethnicity<br>❑ American Indian<br>❑ Asian<br>❑ Black, not of Hispanic origin<br>❑ White, not of Hispanic origin<br>❑ Hispanic/Latino<br>❑ Other |
|---|---|

| Parent/Guardian (Last, First, Middle) | Home Phone Number | Work/Cell Phone Number |
|---|---|---|
| | | |

| Early Childhood Program | Program Phone Number |
|---|---|
| | |

| Primary Health Care Provider | Preferred Hospital | Health Insurance Company/Number* or Medicaid/Number* |
|---|---|---|
| | | |

* If applicable

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

## Part I — To be completed by parent

## *Important*: Complete Part I before your child is examined.

## Take this form with you to the health care provider's office.

Please check answers to the following questions in columns on the left.
(Explain all "yes" answers in the space provided below.)

| | Yes | No | |
|---|---|---|---|
| 1. | ❑ | ❑ | Do you have any concerns about your child's general health, development or behavior? |
| 2. | ❑ | ❑ | Has your child been diagnosed with any chronic disease ❑ asthma ❑ diabetes ❑ seizure disorder ❑ other _____ |
| 3. | ❑ | ❑ | Does your child have any allergies (food, insects, medication, latex, etc.)? Please specify: _____ |
| 4. | ❑ | ❑ | Does your child take any medications (daily or occasionally)? |
| 5. | ❑ | ❑ | Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)? |
| 6. | ❑ | ❑ | Has your child had any hospitalization, operation, major illness or injury, or significant accident? |
| 7. | ❑ | ❑ | In the last 12 months, has your child experienced any difficulty with wheezing or excessive night coughing? |
| 8. | ❑ | ❑ | In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination? |
| 9. | ❑ | ❑ | Has your child had a dental examination in the last 12 months? |
| 10. | ❑ | ❑ | Would you like to discuss anything about your child's health with the child care provider or health consultant/coordinator? |

Please explain any "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

I give permission for release of 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): |
|---|---|---|
| | | |