



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 I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

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, a physician assistant or the school medical advisor 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 10th or 11th grade. Specific grade level will be determined by the local board of education.

Please print

Name of Student (Last, First, Middle)		Social Security Number	Birth Date	Sex
Address (Street)		Race/Ethnicity		
(Town and ZIP code)		<input type="checkbox"/> American Indian	<input type="checkbox"/> White, not of Hispanic origin	
		<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic/Latino	
		<input type="checkbox"/> Black, not of Hispanic origin	<input type="checkbox"/> Other	
Home Telephone Number	School		Grade	
Name of Parent/Guardian (Last, First, Middle)				
Health Care Provider		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.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any concerns about your child's general health (overall eating and sleeping habits, teeth, etc.)?
2.	<input type="checkbox"/>	<input type="checkbox"/>	Has your child been diagnosed with any chronic disease <input type="checkbox"/> asthma <input type="checkbox"/> diabetes <input type="checkbox"/> seizure disorder <input type="checkbox"/> other _____
3.	<input type="checkbox"/>	<input type="checkbox"/>	Does your child have any allergies (food, insects, medication, latex, etc.)?
4.	<input type="checkbox"/>	<input type="checkbox"/>	Does your child take any medications (daily or occasionally)?
5.	<input type="checkbox"/>	<input type="checkbox"/>	Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)?
6.	<input type="checkbox"/>	<input type="checkbox"/>	Has your child had any hospitalization, operation, major illness or injury, or significant accident? (Please specify.)
7.	<input type="checkbox"/>	<input type="checkbox"/>	In the last 12 months, has your child experienced any difficulty with wheezing, excessive coughing or excessive night waking? (Please specify.)
8.	<input type="checkbox"/>	<input type="checkbox"/>	In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination? (Please specify.)
9.	<input type="checkbox"/>	<input type="checkbox"/>	Would you like to discuss anything about your child's health with the school nurse?

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 school.

Signature of Parent/Guardian	Date
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Part II — Medical Evaluation
To the Health Care Provider: Please complete and sign.

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_____ has had a complete history and physical exam on _____
 Student's Name Birth Date Month/Day/Year

Findings for this student are as follows:

Screening/Test Results			Immunization Record					
Note: * Mandated Screening/Test under Connecticut State Law			Vaccine (Month/Day/Year) Note: * Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.					
* Height:		BMI:	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
* Weight:		* Postural:	DTP	*	*	*	*	
* Blood Pressure:		<input type="checkbox"/> Normal	DTP/Hib					
Pulse:		<input type="checkbox"/> Abnormal	DTaP					
* HCT/HGB:		Min. _____	DT/Td					
Urinalysis:		Slight _____	OPV	*	*	*		
* Gross dental:		Mod. _____	IPV	*	*	*		
Lead (Date/Result)		Marked _____	MMR					
			Measles	*	*		Booster for entry into K and 7th grade	
TB and Other Test Results (Sickle Cell, etc.)			Mumps	*				
TB: In high-risk group? <input type="checkbox"/> Yes <input type="checkbox"/> No			Rubella	*				
Test	Date	Results	HIB	*			Students under age 5	
			Hep B	*	*	*	Req. for entry into K and 7th grade.	
* Vision/ Type of Screening	* Auditory/ Type of Screening		Varicella	*			Students born 1/1/97 or later. Required for 7th grade entry.	
With glasses R L	Pass/Fail		PCV				Pneumococcal conjugate vaccine	
20/ 20/	R		Other Vaccines (Specify)					
Without glasses R L	L							
20/ 20/								
* Chronic Disease Assessment:			Disease Hx of above _____ (Specify) _____ (Date) _____ (Confirmed by)					
Yes No			Exemption					
<input type="checkbox"/> <input type="checkbox"/> Asthma: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe			Religious _____ Medical: Permanent _____ Temporary _____ Date _____					
<input type="checkbox"/> exercise induced <input type="checkbox"/> unclassified			Recertify Date _____ Recertify Date _____ Recertify Date _____					
<input type="checkbox"/> <input type="checkbox"/> Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II								
<input type="checkbox"/> <input type="checkbox"/> Anaphylactic Reaction: <input type="checkbox"/> food <input type="checkbox"/> insect <input type="checkbox"/> latex								
<input type="checkbox"/> <input type="checkbox"/> Seizure Disorder								
<input type="checkbox"/> Other: Please specify _____								

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

Vision Auditory Speech/Language Physical Dysfunction Emotional/Social Behavior

The pupil has a health condition which may require emergency action at school, e.g., seizures, allergies, anaphylaxis. *Specify below.*

The pupil is on long-term medication. *Specify below.*

Comments and recommendations (additional information about any of the above health assessment): _____

This student may participate fully in the school program, including physical education activities.

This student may participate in the school program and physical education with the following restriction/adaptation. *(Specify reason and restriction.)* _____

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

I would like to discuss information in this report with the school nurse.

Signature of health care provider	Name/Group Practice (Please type or print.)	Phone Number
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