

## 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
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Name of Child (Last, First, Middle)		Social Security Number		Birth Date	Sex	
Address (Street)			Ethnicity nerican Indian	□ White, not of Hispanic origin		
(Town and ZIP code)		ian ack, not of Hispanic origin	<ul><li>Hispanic/Latino</li><li>Other</li></ul>			
Parent/Guardian (Last, First, Middle)			Home Phone Number		Work/Cell Phon	e Number
Early Childhood Program	Program Phone			Number		
Primary Health Care Provider	Preferred Hospital	Health Insurance Company/Number* or Medicaid/Numb				

\* 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.)

No

- 1.  $\Box$   $\Box$  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.  $\Box$   $\Box$  In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination?
- 9. D Has your child had a dental examination in the last 12 months?
- 10. D 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

To be maintained in the child's Health Record

## 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 His				tory/Physical Exam (mm/dd/yy)				
LENGTH/HEIGHT		WEIGHT		WT FOR H	IT/BMI	HEAD	CIRCUMFE	CRENCE <sup>1</sup>	BLOOD PRESS		SURE <sup>2</sup>
IN/CM %	6ILE	LB/KG	%ILE		%ILE	%ILE IN/CM %ILE		/			
	reening/T	est Resul					Immuni	zation I	Record		
Screening Test Vision <sup>2</sup>	Result	Date A	onormal/C	omments	Vaccine	Month/l	Day/Year)				
Test type:					vacenie		•				
Hearing <sup>3</sup> Test type:					DTP	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
<b>Lead⁴</b> Risk: Yes/No					DTP/Hib DTaP						
<b>TB⁴</b> Risk: Yes/No					DT/Td OPV						
Urinalysis (UA) <sup>4</sup>					IPV						
Anemia <sup>5</sup>					- MMR Measles						
(HGB/HCT) Risk: Yes/No					Mumps						
Developmental					Rubella						
Assessment <sup>6</sup> Test type:					HIB Hep B						
Has this child received	dental	1 1			Varicella						
care in the last 12 mont	hs? <sup>7</sup> 🛛 Ye	es 🗆 No 🗖	N/A		PCV					Pneumococo conjugate va	
* Chronic Disease As Yes No	sessment:			Date of onset			Other Va	accines (S	pecify)	j8	
□ □ Asthma: □ mil		ate 🗆 sever ed 🗆 uncla		onset							
🗅 🗅 Diabetes: 🗅 Typ	ое I 🛛 Тур	e II			Disease H	x					
<ul> <li>Anaphylaxis:</li> <li>Seizures: Type</li> </ul>		od 🗆 insect	□ latex		of above	(Spe	cify)	(Date mm/	yy)	(Confirmed	1 by)
□ □ Other: Please sp					- Exemption						
Minimum requirements: <sup>1</sup> Up to 2 years; <sup>2</sup> annual at 3 years; <sup>3</sup> annual at 4 years; <sup>4</sup> as needed; <sup>5</sup> 9–12 months; <sup>6</sup> each visit through 5 years; <sup>7</sup> annual at 2–3 years. Federal requirements (eg, Head Start, WIC) may vary. *Prior to Public School Entry: Same as above and Hgb/hct.			Religious Medical: Permanent Temporary Date         Recertify Date Recertify Date Recertify Date								
<ul> <li>This child has the follow</li> <li>Vision  Aud</li> <li>The child has a healt long-term medication</li> </ul>	itory h condition	□ Speech/I which may re	anguage. equire int	P ervention at	hysical Dys the program	sfunction n, e.g., se	L H				ehavior tial diet,
□   Yes   □   No   Based     □   The child may fully	cipate safely on this comp participate i		am. tory and p n.	hysical exan	nination, this	s child has	s maintained	l his/her lev	vel of welln	ess.	oility to
The child may fully	participate	in the program	n with th	e following	restrictions/	adaptatio	n: (Specify	reason and	d restrictio	n.)	
□ I would like to discu	iss informat	ion in this rep			ldhood prov	vider and	or health co	onsultant/c	oordinator	•	
Signature of health care	provider		MD/DO NP PA	Name (Pl	ease type of	ase type or print.)			Phone number		
Address:				1					I <u> </u>		
□ Yes □ No Is this t	the child's N	Aedical Home	e? Next	Appointmer	t (mm/yy):		Next Immu	inization A	ppointme	nt (mm/yy)	):