

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.

P	lease 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	Native 📮 Hispanic/Latino		
Primary Health Care Provider:	Black, not of Hispanic orig	1		
Name of Dentist:	U White, not of Hispanic orig	gin 🛛 Other		
Health Insurance Company/Number* or Medicaid/Number*				
Does your child have health insurance?YNDoes your child have dental insurance?YNDoes your child have HUSKY insurance?YN	If your child does not have health insu	irance, call 1-877-CT-HUSKY		

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

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 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

I have reviewed the health history information provided in Part 1 of this form (mmidd/yyyy) (mmidd/yyyy) Physical Exam New: "Mandaded Screening," (Mmidd/yyyy) (Mmidd/yyyy) Wite: "Mandaded Screening," (Mith 2 4 months) (Mmidd/yyyy) (Mmidd/yyyy) Screening "Hearing Screening," (Mith 3 yz) (Mmidd/yyyy) (Mmidd/yyyy) PINDT Subjective Screen Completed (Birth 10 3 yz) "Hearing Screening," (Harry and Periodic Screening," (Harry and Perio	Child's Name			Birth Date	Date of Exam	
Note: *Mandated Screening/Test to be completed by provider. "Image:				ı (mm	/dd/yyyy)	(mm/dd/yyyy)
Screenings **Nom Screening **Anemia: at 9 to 12 months and 2 yeas **Nom Screening FPSDT Subjective Screen Completed (Birth to 3 yss) **Remia: at 9 to 12 months and 2 yeas EFSDT Annually at 3 yss (Bryn and Periodic Screening, Diagnosis and Treatment) **Remin: at 9 to 12 months and 2 yeas Type: Right Left With glasses 20/ 20/ Unable to assess PBSDT Subjective Screen **Result: Type: Right Left Vithout glasses 20/ 20/ Unable to assess Pass Pass Referral made to: **Denial Concerns No Yes Test done: No Yes *Result/Level: *Date **Results: **Developmental Assessment: **Differentiation on the Referral made to: **The Right-risk group? No **Results: **IMMUNIZATIONS Up to Date or Catch-up Schedule: MUST HAVE IMMUNIZATION RECORD ATTACHED **Chronic Discase Assessment: Mid Persisteni Moderate Persistent Severe Persistent Exercise induced Hyse, please provide a corp of an Asthma Actian Plan Babetes No Yes Yes For Pon required: No Yes	Note: *Mandat	ed Screening/Test to be completed				ure/
• Vision Sercening • "Ilcaring Sercening • "Anemia: at 9 to 12 months and 2 years • BPSDT Subjective Screen Completed (Brith in 3 yrs) • BPSDT Subjective Screen Completed (Brith in 3 yrs) • *Anemia: at 9 to 12 months and 2 years • BPSDT Annually at 3 yrs • BPSDT Subjective Screen Completed (Brith in 4 yrs) • Parss • Parss • Diagnosis and Treatment) • Diagnosis and Treatment) • Parss • Parss • With glasses 20/ 20/ • Pars • Parss • Without glasses 20/ 20/ • Pars • Parss • Referral made to: • Pars • Pars • Parse • * Cardit and 2 years: if no result screen between 25 - 72 months • Without glasses 20/ 20/ • Pars • Between 25 - 72 months • * Date • Referral made to: • Between made to: • Between made to: • * Date • Date • Date • Date • TB: High-risk group? • No Yes • Date • Detate Concerns No Yes • Other: • Trainment: • No Yes • Date • Catch-up Schedule: <u>MUNTIZATION RECORD ATTACHED</u> • Milergies • No Yes • Intermi	Screening	28		(Birth – 2	(Annually	at 3 – 5 years)
Type: Right Left Type: Right Left With glasses 20/20/20/20/20/20/20/20/20/20/20/20/20/2	*Vision Scree EPSDT Sul (Birth to 3 EPSDT An (Early and	ning bjective Screen Completed yrs) nually at 3 yrs Periodic Screening,	 EPSDT Subjective Screet (Birth to 4 yrs) EPSDT Annually at 4 yr (Early and Periodic Screet) 	vrs reening,		-
Yes Test done: No Yes Date:	With glas Without g	ses 20/ 20/ glasses 20/ 20/ issess	PassFailUnable to assess	PassFail	*Lead: at 1 and 2 years; i screen between 25 – 72 r History of Lead level	f no result nonths
Results: *IMMUNIZATIONS Up to Date or Catch-up Schedule: MUST HAVE IMMUNIZATION RECORD ATTACHED *Chronic Disease Assessment: Asthma yes; Intermittent Mild Persistent Moderate Persistent Severe Persistent Exercise induced yes; please provide a copy of an Asthma Action Plan Rescue medication required in child care setting: No Yes Allergies No Yes: No Yes: Fpi Pen required: No Yes: Epi Pen required: No Yes: Food Insects Latex Medication Unknown source fyes, please provide a copy of the Emergency Allergy Plan Diabetes No Yes: Type I Other Chronic Disease: Seizures No Yes: Type I Other Chronic Disease: Seizures No Yes: Type: Other Chronic Disease: '' Nision Additory Speech/Language Physical Emotional/Social Behavior This child has a special health care need which may adversely affect his or her educational experience: '' Vision Additory of contagious disease. Specify:	Yes Test done Results:	: 🗆 No 🗳 Yes Date:	Referral made to: Has this child received der	ntal care in		*Date
*IMMUNIZATIONS Up to Date or Catch-up Schedule: MUST HAVE IMMUNIZATION RECORD ATTACHED *Chronic Disease Assessment: Asthma No Ves: Intermittent Mild Persistent Moderate Persistent Severe Persistent Exercise induced If yes, please provide a copy of an Asthma Action Plan Rescue medication required in child care setting: No Yes Allergies No Yes: Food Yes: Food Insects Latex Medication Unknown source If yes, please provide a copy of the Emergency Allergy Plan Diabetes No Yes: Type I Type I Type II Other Chronic Disease: Secure Persistent Other Chronic Disease: Secure Persistent Other Chronic Disease: Secure Private Auditory Secure Private Privat	*Developme	ental Assessment: (Birth – 5 year	ars) 🗆 No 🖵 Yes	Туре:		
*Chronic Disease Assessment: Asthma No Yes: Intermittent Mild Persistent Moderate Persistent Severe Persistent Exercise induced <i>If yes, please provide a copy of an Asthma Action Plan</i> Rescue medication required in child care setting: No Yes Allergies No Yes: No Yes: Food Insects Latex Medication Unknown source <i>If yes, please provide a copy of the Emergency Allergy Plan</i> Diabetes No Yes: Food Insects Latex Medication Unknown source <i>If yes, please provide a copy of the Emergency Allergy Plan</i> Other Chronic Disease:	Results:					
Asthma No Yes: Intermittent Mild Persistent Moderate Persistent Severe Persistent Exercise induced If yes, please provide a copy of an Asthma Action Plan Rescue medication required in child care setting: No Yes Allergies No Yes: No Yes: Provide a copy of the Emergency Allergy Plan Diabetes No Yes: Type I Other Chronic Disease: Provide a copy of the Emergency Allergy Plan Diabetes No Yes: Type I Other Chronic Disease: Provide a copy of the Emergency Allergy Plan Diabetes No Yes: Type I Type II Other Chronic Disease: Provide a copy of the Emergency Allergy Plan Diabetes No Yes: Type I Type II Other Chronic Disease: Provide a copy of the Emergency Allergy Plan Diabetes No Yes: Type I Pype II Other Chronic Disease: Provide a copy of the Emergency Allergy Plan Diabetes No Yes: Type I Pype II Pype II Other Chronic Disease: Provide a copy of the Emergency Allergy Plan Diabetes No Yes: Type II	*IMMUNI	ZATIONS Up to Date	or Catch-up Schedule:	MUST HAVE IM	IMUNIZATION RECOR	ATTACHED
Epi Pen required: No Yes History/risk of Anaphylaxis: No Yes: Food Insects Latex Medication Unknown source If yes, please provide a copy of the Emergency Allergy Plan Diabetes No Yes: Type I Type II Other Chronic Disease: Seizures No Yes: Type I Type II Other Chronic Disease: Vision Auditory Speech/Language Physical Emotional/Social Behavior This child has the following problems which may adversely affect his or her educational experience: Vision Auditory Speech/Language Physical Emotional/Social Behavior This child has a developmental delay/disability that may require intervention at the program. This child has a special health care need which may require intervention at the program. No Yes No Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program. No Yes This child has a fully participate in the program. No Yes No Yes This child has y fully participate in the program. No Yes This child may fu		□ No □ Yes: □ Intermitter If yes, please provide a copy of an	Asthma Action Plan		Severe Persistent	Exercise induced
Seizures No Yes: Type: This child has the following problems which may adversely affect his or her educational experience: Vision Auditory Speech/Language Physical Emotional/Social Behavior This child has a developmental delay/disability that may require intervention at the program. This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. <i>Specify:</i> No Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program. No Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness. No Yes This child may fully participate in the program. No Yes This child may fully participate in the program. No Yes Is this the child's medical home? I would like to discuss information in this report with the early childhood provider	Allergies	Epi Pen required: History/risk of Anaphylaxis:	No 🛛 Yes: 🖵 Food	Insects Latex	□ Medication □ Unknown	1 source
 This child has the following problems which may adversely affect his or her educational experience: Vision Auditory Speech/Language Physical Emotional/Social Behavior This child has a developmental delay/disability that may require intervention at the program. This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. <i>Specify:</i> No Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program. No Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness. No Yes This child may fully participate in the program. No Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.) No Yes Is this the child's medical home? I would like to discuss information in this report with the early childhood provider 				er Chronic Disease:		
 safely in the program. No Q Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness. No Q Yes This child may fully participate in the program. No Q Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.) No Q Yes Is this the child's medical home? Q I would like to discuss information in this report with the early childhood provider 	 This child Vision This child This child 	has the following problems which r Auditory Speech/Languag has a developmental delay/disabilit has a special health care need which	may adversely affect his or here ge	nal/Social Dehav n at the program. he program, e.g., spec	vior sial diet, long-term/ongoing/da	aily/emergency
	□ No □ Yes □ No □ Yes	safely in the program. Based on this comprehensive hist This child may fully participate in	ory and physical examination n the program.	, this child has mainta	ined his/her level of wellness	
	🗆 No 📮 Yes	Is this the child's medical home?		-	ort with the early childhood p	rovider

Date Signed

Printed/Stamped Provider Name and Phone Number

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

Birth Date: _____

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year)

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6	
DTP/DTaP/DT							
IPV/OPV							
MMR							
Measles							
Mumps							
Rubella							
Hib							
Hepatitis A							
Hepatitis B							
Varicella							
PCV* vaccine					*Pneumococcal cor	ijugate vaccine	
Rotavirus							
MCV**					**Meningococcal co	njugate vaccine	
Influenza							
Tdap/Td							
Disease history for varicella (chickenpox)							
		(D	ate)	(Confirmed by)			
Exemption:	Religious	Medical: P	ermanent	†Temporary	Date	_	

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

 †Recertify Date _____
 †Recertify Date _____

 †Recertify Date _____
 †Recertify Date _____

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2 years of age (24-35 mos.)	3-5 years of age (36-59 mos.)
DTP/DTaP/ DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday ¹				
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given ³	1 booster dose after 1st birthday ⁴				
Varicella	None	None	None	None	1 dose after 1 st birthday or prior history of disease ^{1,2}	1 dose after 1 st birthday or prior history of disease ^{1,2}	1 dose after 1 st birthday or prior history of disease ^{1,2}	1 dose after 1 st birthday or prior history of disease ^{1,2}	1 dose after 1 st birthday or prior history of disease ^{1,2}
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday				
Hepatitis A	None	None	None	None	1 dose after 1st birthday ⁵	1 dose after 1st birthday ⁵	1 dose after 1st birthday ⁵	2 doses given 6 months apart ⁵	2 doses given 6 months apart ⁵
Influenza	None	None	None	1 or 2 doses	1 or 2 doses ⁶				

1. Laboratory confirmed immunity also acceptable

2. Physician diagnosis of disease

3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)

4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose

5. Hepatitis A is required for all children born on or after January 1, 2009

6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons