

Connecticut Early Childhood Health Assessment Record

To Parent or Guardian:

In order to provide the best experience, early childhood providers must understand you child's health needs. This form requests information from you (part I) which will also 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 legally qualified practitioner of medicine, an advanced practice registered nurse, a physician assistant or the school medical advisor prior to entering and early childhood program in Connecticut.

Please Print

Name of Child (Last, First, Middle)		Social Security Number	Birth Date	Sex
Address (Street)			Home Telephone Number	
(Town and Zip Code)	Early Childhood Program		Program Number	
Parent/Guardian (Last, First, Middle)	Home Telephone Number		Work Telephone Number	
Medicaid Number*if applicable			Health Insurance Company/Number	

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 (eating and sleeping habits, weight, teeth, etc.)? |
| 2. <input type="checkbox"/> | <input type="checkbox"/> | Do you have any concerns about your child's development or behavior? |
| 3. <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any allergies (food, insects, medication, etc)? |
| 4. <input type="checkbox"/> | <input type="checkbox"/> | Does your child take any medication (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, or major illness (specify problem)? |
| 7. <input type="checkbox"/> | <input type="checkbox"/> | Has your child had any significant injury or accident (specify problem)? |
| 8. <input type="checkbox"/> | <input type="checkbox"/> | Is your child receiving any special services? |
| 9. <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any other specific illness or problem? |
| 10. <input type="checkbox"/> | <input type="checkbox"/> | Would you like to discuss anything about your child's health with the child care provider or health consultant? |

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

I give permission for the 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

To be maintained in child's Health Record

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.

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

Health history and medical information pertinent to routine care, special diet, and Emergencies: _____ None _____		Allergies to food, medicine, or insects: _____ None _____	
Length/Height _____ IN/CM _____ %ile	Weight _____ lb/kg _____ %ile	Head Circumference _____ IN/CM _____ %ile	Blood Pressure _____ / _____
Physical Examination	Normal	Abnormal/Comments	
Head/Ears/Eyes/Nose/Throat			
Teeth			
Cardiorespiratory			
Abdomen/GI			
Genitalia/Breasts			
Extremities/ Joints/ Back/ Chest			
Skin/ Lymph Nodes			
Neurologic /Tone			
Development			
Immunizations	Date	Date	Date
DTP/DtaP			
Polio			
HIB			
HEP B			
MMR			
Varicella			
Pneumococcal			
Other			
Disease Hx of above or contagious disease Specify _____ Date _____ Confirmed by _____		Exemption Religious __ Medical __ Permanent__ Temporary __ Date _____	
Screening Tests	Results	Date	Abnormal/Comments
Vision (type of Screening _____)2			
Hearing (type of Screening _____)3			
Lead 4			
Anemia (HGB/HCT)4			
Urinalysis (UA)5			
TB (risk? Yes/No)5			
Developmental Assessment 6			
Date of last dentist examination 7 _____			

Minimum requirements: 1-Up to 2 years, 2- annual, 3-annual at 4 years, 4- 9-12 months, 2 years, 5- as needed, 6-each visit through 5 yrs, 7- annual at 2-3 years Prior to Public School Entry: Same as Above and Hgb/hct

This child has the following conditions which may affect the educational experience:
 ___ Vision ___ Auditory ___ Speech/Language ___ Physical Dysfunction ___ Emotional/Social ___ Behavior
 Re: Licensing: Does this child have 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

___ This child has a health condition which may require emergency action at school, e.g., seizures, allergies, asthma. Specify Below.
 ___ The child is on long-term or emergency medication. Specify Below

Comments and recommendations (attach additional sheet if necessary):

___ This child may participate fully in the early childhood program.
 ___ This child may participate in the early childhood program with the following restrictions/adaptations: (specify reason and restriction)

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

___ 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 print or type)	Phone Number
Address		Next Appointment (Mo/Yr) Next Appointment for Immunizations (Mo/Yr)