



# 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)	Home Telephone Number		
(Town and ZIP code)	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?<br><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"/> | Has your child experienced any difficulty with wheezing, excessive coughing, excessive night waking, excessive weight loss or weight gain, or excessive thirst or urination? (Please specify.)               |
| 8. | <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.

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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

To the Health Care Provider: Please complete and sign.

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

Findings for this student are as follows:

Screening/Test Results	Immunization Record																																																																																																																																									
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**TB and Other Test Results** (Sickle Cell, etc.)

TB: In high-risk group?  Yes  No

Test	Date	Results

* Vision/ Type of Screening	* Auditory/ Type of Screening
With glasses R L 20/ 20/	Pass/Fail R
Without glasses R L 20/ 20/	L

**\* Chronic Disease Assessment:**

Asthma:  mild  moderate  severe  exercise induced  unclassified

Diabetes:  Type I  Type II

Anaphylactic Reaction:  food  insect  latex

Seizure Disorder

Other: Please specify \_\_\_\_\_

**Other Vaccines (Specify)**


**Disease Hx of above** \_\_\_\_\_ (Specify) \_\_\_\_\_ (Date) \_\_\_\_\_ (Confirmed by)

**Exemption**

Religious \_\_\_\_\_ Medical: Permanent \_\_\_\_\_ Temporary \_\_\_\_\_ Date \_\_\_\_\_

Recertify Date \_\_\_\_\_ Recertify Date \_\_\_\_\_ Recertify Date \_\_\_\_\_

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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