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) (Town and ZIP code)	Race/Ethnicity ❑ American Indian ❑ White, not of Hispanic origin ❑ Asian ❑ Hispanic/Latino ❑ Black, not of Hispanic origin ❑ 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.	❑	❑	Do you have any concerns about your child's general health (overall eating and sleeping habits, teeth, etc.)?
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.)?
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? (Please specify.)
7.	❑	❑	In the last 12 months, has your child experienced any difficulty with wheezing, excessive coughing or excessive night waking? (Please specify.)
8.	❑	❑	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.	❑	❑	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

To be maintained in the student's Cumulative School Health Record

Part II — Medical Evaluation

HAR-3 REV. 1/2005

To the Health Care Provider: Please complete and sign.

_____ _____ 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

Note: * Mandated Screening/Test under Connecticut State Law

* Height:		BMI:
* Weight:		* Postural:
* Blood Pressure:		❑ Normal
Pulse:		❑ Abnormal
* HCT/HGB:		Min. _____
Urinalysis:		Slight _____
* Gross dental:		Mod. _____
Lead (Date/Result)		Marked _____
		❑ Referral

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 20/	L 20/	Pass/Fail R
Without glasses	R 20/	L 20/	L

*** Chronic Disease Assessment:**

Yes	No		Date of onset
❑	❑	Asthma: ❑ mild ❑ moderate ❑ severe ❑ exercise induced ❑ unclassified	
❑	❑	Diabetes: ❑ Type I ❑ Type II	
❑	❑	Anaphylactic Reaction: ❑ food ❑ insect ❑ latex	
❑	❑	Seizure Disorder	
❑	❑	Other: Please specify _____	

Immunization Record

Vaccine (Month/Day/Year) Note: * Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP	*	*	*	*		
DTP/Hib						
DTaP						
DT/Td						
OPV	*	*	*			
IPV	*	*	*			
MMR						
Measles	*	*		Booster for entry into K and 7th grade		
Mumps	*					
Rubella	*					
HIB	*				Students under age 5	
Hep B	*	*	*		Req. for entry into K and 7th grade.	
Varicella	*			Students born 1/1/97 or later. Required for 7th grade entry.		
PCV					Pneumococcal conjugate vaccine	

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