# 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 1) which will be helpful to the health care provider when he or she completes the health evaluation (Part 2) and oral health assessment (Part 3). 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.

*Please 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<br>❑American Indian/Alaska Native ❑Native Hawaiian/Pacific Islander<br>❑Asian ❑White<br>❑Black or African American ❑Other<br>❑Hispanic/Latino of any race | |
| Primary Health Care Provider:<br>Name of Dentist: | | |
| Health Insurance Company/Number* or Medicaid/Number* | | |

| | | | |
|---|---|---|---|
| Does your child have health insurance? | Y | N | If your child does not have health insurance, call **1-877-CT-HUSKY** |
| Does your child have dental insurance? | Y | N | |
| Does your child have HUSKY insurance? | Y | N | |

* If applicable

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

**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 2 — Medical Evaluation

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

Child's Name _____ Birth Date _____ (mm/dd/yyyy) Date of Exam _____ (mm/dd/yyyy)

❑I have reviewed the health history information provided in Part I of this form

## Physical Exam Immunization record attached.

**Note:** *Mandated Screening/Test to be completed by provider.

***HT**____in/cm_____% ***Weight**____lbs._____oz /_____% **BMI**____/_____% ***HC**____in/cm_____% (Birth–24 months) ***Blood Pressure**____/____ (Annually at 3–5 years)

## Screenings

***Vision Screening**
- ❑ EPSDT Subjective Screen Completed (Birth to 3 yrs.)
- ❑ EPSDT Annually at 3 yrs. (Early and Periodic Screening, Diagnosis and Treatment)

| Type: | Right | Left |
|---|---|---|
| With glasses | 20/ | 20/ |
| Without glasses | 20/ | 20/ |

❑Unable to assess

❑Referral made to: _____

***Hearing Screening**
- ❑ EPSDT Subjective Screen Completed (Birth to 4 yrs.)
- ❑ EPSDT Annually at 4 yrs. (Early and Periodic Screening, Diagnosis and Treatment)

| Type: | Right | Left |
|---|---|---|
| | ❑ Pass | ❑Pass |
| | ❑ Fail | ❑Fail |

❑Unable to assess

❑Referral made to: _____

***Anemia:** at 9 to 12 months and 2 years

***Hgb/Hct:** *Date

***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months

History of Lead level ≥ 5µg/dL ❑No ❑Yes

***TB:** High-risk group? ❑No ❑Yes

Test done: ❑No ❑Yes Date: _____

Results: _____

Treatment: _____

***Dental Concerns** ❑No ❑Yes

❑Referral made to: _____

Has this child received dental care in the last 6 months? ❑No ❑Yes

*Result/Level: *Date

**Other:**

***Developmental Assessment:** (Birth–5 years) ❑No ❑Yes **Type:**

**Results:**

## *IMMUNIZATIONS ❑Up to Date or ❑Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

**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: _____
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

**Seizures** ❑No ❑Yes: Type: _____

**Other Chronic Disease:** _____

❑ 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. *Specify:* _____

❑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 and/or nurse/health consultant/coordinator.

Pediatric Associates of Farmington, LLC
200 Mountain Road, Farmington, CT 06032
T: 860-676-9000 F: 860-676-1541
Deepa Limaye, MD / Lisa Petricca, PA-C

Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number

# Part 3 — Oral Health Assessment/Screening

**Health Care Provider must complete and sign the oral health assessment.**

To Parent(s) or Guardian(s):
State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

| Student Name (Last, First, Middle) | Birth Date | Date of Exam |
|---|---|---|
| School | Grade | ❑Male ❑Female |
| Home Address | | |
| Parent/Guardian Name (Last, First, Middle) | Home Phone | Cell Phone |

| **Dental Examination** | **Visual Screening** | Normal | **Referral Made:** |
|---|---|---|---|
| Completed by:<br>❑Dentist | Completed by:<br>❑MD/DO<br>❑APRN<br>❑PA<br>❑Dental Hygienist | ❑Yes<br>❑Abnormal (Describe)<br>_____<br>_____<br>_____<br>_____<br>_____ | ❑Yes<br>❑No |

| **Risk Assessment** | **Describe Risk Factors** | |
|---|---|---|
| ❑Low | ❑Dental or orthodontic appliance | ❑Carious lesions |
| ❑Moderate | ❑Saliva | ❑Restorations |
| ❑High | ❑Gingival condition | ❑Pain |
| | ❑Visible plaque | ❑Swelling |
| | ❑Tooth demineralization | ❑Trauma |
| | ❑Other _____ | ❑Other _____ |

Recommendation(s) by health care provider: _____

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian — Date

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Deepa Limaye, MD / Lisa Petricca, PA-C

Signature of health care provider — DMD / DDS / MD / DO / APRN / PA/ RDH — Date Signed — Printed/Stamped ***Provider*** Name and Phone Number

**Child's Name:** _____ **Birth Date:** _____ REV. 10/2018

Immunization record attached **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 conjugate vaccine | |
| **Rotavirus** | | | | | | |
| **MCV**** | | | | | **Meningococcal conjugate vaccine | |
| **Flu** | | | | | | |
| **Other** | | | | | | |

**Disease history for varicella (chickenpox)** _____
(Date) (Confirmed by)

**Exemption:** **Religious** _____ **Medical: Permanent** _____ **†Temporary** _____ **Date** _____
†Recertify Date _____ †Recertify Date _____ †Recertify Date _____

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

| 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 | 2–3 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] | 1 dose after 1st birthday[1] | 1 dose after 1st birthday[1] | 1 dose after 1st birthday[1] | 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] | 1 booster dose after 1st birthday[4] | 1 booster dose after 1st birthday[4] | 1 booster dose after 1st birthday[4] | 1 booster dose after 1st birthday[4] |
| **Varicella** | None | None | None | None | None | None | 1 dose after 1st birthday or prior history of disease[1,2] | 1 dose after 1st birthday or prior history of disease[1,2] | 1 dose after 1st birthday or prior history of disease[1,2] |
| **Pneumococcal Conjugate Vaccine (PCV)** | None | 1 dose | 2 doses | 3 doses | 1 dose after 1st birthday | 1 dose after 1st birthday | 1 dose after 1st birthday | 1 dose after 1st birthday | 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 or 2 doses[6] | 1 or 2 doses[6] | 1 or 2 doses[6] | 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 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

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DLimaye — Deepa Limaye, MD / Lisa Petricca, PA-C

Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number