



State of Connecticut Early Childhood Health Assessment Record



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 also be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunization 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 an early childhood program in Connecticut.

Please print

Name of Child (Last, First, Middle)		Social Security Number	Birth Date	Sex
Address (Street)		Race/Ethnicity <input type="checkbox"/> American Indian <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Other		
(Town and ZIP code)				
Parent/Guardian (Last, First, Middle)		Home Phone Number	Work/Cell Phone Number	
Early Childhood Program			Program Phone Number	
Primary Health Care Provider	Preferred Hospital	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, development or behavior? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Has your child been diagnosed with any chronic disease <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.)? Please specify: _____ |
| 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? |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | In the last 12 months, has your child experienced any difficulty with wheezing or excessive night coughing? |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination? |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | Has your child had a dental examination in the last 12 months? |
| 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/coordinator? |

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 the early childhood program.

Signature of Parent/Guardian	Date
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Part II -- Health Evaluation

To the Health Care Provider: Please complete all sections and sign. Explain any screenings required by age but not conducted.

Child's Name _____ Birth Date (mm/dd/yy) _____ Date of History/Physical Exam (mm/dd/yy) _____

LENGTH/HEIGHT		WEIGHT		WT FOR HT/BMI	HEAD CIRCUMFERENCE ¹		BLOOD PRESSURE ²
IN/CM	%ILE	LB/KG	%ILE	%ILE	IN/CM	%ILE	/

Screening/Test Results				Immunization Record									
Screening Test	Result	Date	Abnormal/Comments	Vaccine (Month/Day/Year)									
Vision ² Test type: _____				Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6				
Hearing ³ Test type: _____				DTP									
Lead ⁴ Risk: Yes/No				DTP/Hib									
TB ⁴ Risk: Yes/No				DTaP									
Urinalysis (UA) ⁴				DT/Td									
Anemia ⁵ (HGB/HCT) Risk: Yes/No				OPV									
Developmental Assessment ⁶ Test type: _____				IPV									
Has this child received dental care in the last 12 months? ⁷ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				MMR									
* Chronic Disease Assessment: Yes No _____ Date of onset _____ <input type="checkbox"/> <input type="checkbox"/> Asthma: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> exercise induced <input type="checkbox"/> unclassified <input type="checkbox"/> <input type="checkbox"/> Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> <input type="checkbox"/> Anaphylaxis: <input type="checkbox"/> med. <input type="checkbox"/> food <input type="checkbox"/> insect <input type="checkbox"/> latex <input type="checkbox"/> <input type="checkbox"/> Seizures: Type _____ <input type="checkbox"/> <input type="checkbox"/> Other: Please specify _____				Measles									
				Mumps									
				Rubella									
				HIB									
				Hep B									
				Varicella									
				PCV									Pneumococcal conjugate vaccine
				Other Vaccines (Specify)									
				Disease Hx of above _____ (Specify) _____ (Date mm/yy) _____ (Confirmed by) _____									
				Exemption									
				Religious _____ Medical: Permanent _____ Temporary _____ Date _____									
				Recertify Date _____ Recertify Date _____ Recertify Date _____									

This child has the following problems which may adversely affect his or her educational experience:

Vision Auditory Speech/Language Physical Dysfunction Emotional/Social Behavior

The child has a health condition which may require intervention at the program, e.g., seizures, allergies, asthma, anaphylaxis, special diet, long-term medication. *Specify:* _____

- Yes No This child has 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 Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.
- The child may fully participate in the program.
- The child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.) _____

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 type or print.)	Phone number GALES FERRY PEDIATRICS P. O. BOX 608 GALES FERRY, CT 06335 (860) 464-7248
Address: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No Is this the child's Medical Home?	Next Appointment (mm/yy): _____ Next Immunization Appointment (mm/yy): _____