



# 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 I) which will be 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 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)	<input type="checkbox"/> Male <input type="checkbox"/> 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	
Primary Health Care Provider:	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Other	
Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		
Does your child have health insurance?	Y   N	
Does your child have dental insurance?	Y   N	If your child does not have health insurance, call <b>1-877-CT-HUSKY</b>
Does your child have HUSKY insurance?	Y   N	

\* If applicable

### Part I — 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 examination in the last 6 months	Y	N	Any heart problems	Y	N
Any daily/ongoing medications	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
<b>Developmental — Any concern about your child’s:</b>						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 to another	Y	N	6. Interaction with others	Y	N	Eating concerns	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 II – Medical Evaluation

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

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Date of Exam \_\_\_\_\_

I have reviewed the health history information provided in Part I of this form (mm/dd/yyyy) (mm/dd/yyyy)

### Physical Exam

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

\*HT \_\_\_\_ in/cm \_\_\_\_%    \*Weight \_\_\_\_ lbs. \_\_\_\_ oz / \_\_\_\_%    BMI \_\_\_\_ / \_\_\_\_%    \*HC \_\_\_\_ in/cm \_\_\_\_%    \*Blood Pressure \_\_\_\_ / \_\_\_\_  
(Birth – 24 months) (Annually at 3 – 5 years)

### Screenings

<p><b>*Vision Screening</b></p> <p><input type="checkbox"/> EPSTD Subjective Screen Completed (Birth to 3 yrs)</p> <p><input type="checkbox"/> EPSTD Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment)</p> <p>Type:                      <u>Right</u>      <u>Left</u></p> <p style="margin-left: 40px;">With glasses            20/            20/</p> <p style="margin-left: 40px;">Without glasses        20/            20/</p> <p><input type="checkbox"/> Unable to assess</p> <p><input type="checkbox"/> Referral made to: _____</p>	<p><b>*Hearing Screening</b></p> <p><input type="checkbox"/> EPSTD Subjective Screen Completed (Birth to 4 yrs)</p> <p><input type="checkbox"/> EPSTD Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment)</p> <p>Type:                      <u>Right</u>      <u>Left</u></p> <p style="margin-left: 40px;"><input type="checkbox"/> Pass            <input type="checkbox"/> Pass</p> <p style="margin-left: 40px;"><input type="checkbox"/> Fail             <input type="checkbox"/> Fail</p> <p><input type="checkbox"/> Unable to assess</p> <p><input type="checkbox"/> Referral made to: _____</p>	<p><b>*Anemia:</b> at 9 to 12 months and 2 years</p> <hr/> <p><b>*Hgb/Hct:</b> _____      <b>*Date:</b> _____</p> <hr/> <p><b>*Lead:</b> at 1 and 2 years; if no result screen between 25 – 72 months</p> <p style="margin-left: 20px;">Lead poisoning (≥ 10ug/dL)</p> <p style="margin-left: 20px;"><input type="checkbox"/> No    <input type="checkbox"/> Yes</p> <hr/> <p><b>*Result/Level:</b> _____      <b>*Date:</b> _____</p> <hr/> <p><b>Other:</b> _____</p>
<p><b>*TB:</b> High-risk group?    <input type="checkbox"/> No    <input type="checkbox"/> Yes</p> <p>Test done:    <input type="checkbox"/> No    <input type="checkbox"/> Yes    Date: _____</p> <p>Results: _____</p> <p>Treatment: _____</p>	<p><b>*Dental Concerns</b>    <input type="checkbox"/> No    <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Referral made to: _____</p> <p>Has this child received dental care in the last 6 months?    <input type="checkbox"/> No    <input type="checkbox"/> Yes</p>	

**\*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      **Other Chronic Disease:** \_\_\_\_\_

**Seizures**     No     Yes:    Type: \_\_\_\_\_

- 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.

Signature of health care provider MD / DO / APRN / PA	Date Signed	Printed/Stamped <b>Provider</b> Name and Phone Number
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# 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 <sup>1</sup>	1 dose after 1st birthday <sup>1</sup>	1 dose after 1st birthday <sup>1</sup>	1 dose after 1st birthday <sup>1</sup>	1 dose after 1st birthday <sup>1</sup>
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 <sup>3</sup>	1 booster dose after 1st birthday <sup>4</sup>	1 booster dose after 1st birthday <sup>4</sup>	1 booster dose after 1st birthday <sup>4</sup>	1 booster dose after 1st birthday <sup>4</sup>	1 booster dose after 1st birthday <sup>4</sup>
Varicella	None	None	None	None	None	None	1 dose after 1st birthday or prior history of disease <sup>1,2</sup>	1 dose after 1st birthday or prior history of disease <sup>1,2</sup>	1 dose after 1st birthday or prior history of disease <sup>1,2</sup>
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 <sup>5</sup>	1 dose after 1st birthday <sup>5</sup>	1 dose after 1st birthday <sup>5</sup>	2 doses given 6 months apart <sup>5</sup>	2 doses given 6 months apart <sup>5</sup>
Influenza	None	None	None	1 or 2 doses	1 or 2 doses <sup>6</sup>	1 or 2 doses <sup>6</sup>	1 or 2 doses <sup>6</sup>	1 or 2 doses <sup>6</sup>	1 or 2 doses <sup>6</sup>

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

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