Rocky Hill Public School's is committed to providing a website that is accessible to the widest possible audience, regardless of technology or ability. This website endeavors to comply with best practices and standards defined by Section 508 of the U.S. Rehabilitation Act. If you are having difficulties accessing this form and would like additional assistance or have accessibility concerns, please contact Katie DeLoureiro at 860-258-7701 ext. 1163. We are always striving to improve the accessibility standards of our website.

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 ❑American Indian/Alaska Native ❑Native Hawaiian/Pacific Islander ❑Asian ❑White ❑Black or African American ❑Other ❑Hispanic/Latino of any race	
Primary Health Care Provider: 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 Does your child have HUSKY insurance? Y N	If your child does not have health insurance, call **1-877-CT-HUSKY**	

* 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 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
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 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

C.G.S. Section 10-16q, 10-206, 19a.79(a), 19a-87b(c); P.H. Code Section 19a-79-5a(a)(2), 19a-87b-10b(2); Public Act No. 18-168.

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

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 ❑nNo ❑nYes

***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 childcare 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 ***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: ❑Dentist	Completed by: ❑MD/DO ❑APRN ❑PA ❑Dental Hygienist	❑Yes ❑Abnormal (Describe) _____ _____ _____ _____ _____	❑Yes ❑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

_____

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. 1/2022

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						

Religious Exemption: _____

Religious exemptions must meet the criteria established in Public Act 21-6: https://www.ctoec.org/wp-content/uploads/2021/07/OEC-Vaccination-QA-Final.pdf.

Medical Exemption: _____

Must have signed and completed medical exemption form attached. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf

Disease history of varicella: _____(date); _____(confirmed by)

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

_____

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

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

IMMUNIZATION REQUIREMENTS FOR ENROLLED STUDENTS IN CONNECTICUT SCHOOLS

2022-2023 SCHOOL YEAR

PRESCHOOL

Hep B:	3 doses, last one on or after 24 weeks of age
DTaP:	4 doses (by 18 months for programs with children 18 months of age)
Polio:	3 doses (by 18 months for programs with children 18 months of age)
MMR:	1 dose on or after 1st birthday
Varicella:	1 dose on or after 1st birthday or verification of disease
Hepatitis A:	2 doses given six calendar months apart, 1st dose on or after 1st birthday
Hib:	1 dose on or after 1st birthday
Pneumococcal:	1 dose on or after 1st birthday
Influenza:	1 dose administered each year between August 1st-December 31st (2 doses separated by at least 28 days required for those receiving flu for the first time)

KINDERGARTEN

Hep B:	3 doses, last dose on or after 24 weeks of age
DTaP:	At least 4 doses. The last dose must be given on or after 4th birthday
Polio:	At least 3 doses. The last dose must be given on or after 4th birthday
MMR:	2 doses separated by at least 28 days, 1st dose on or after 1st birthday
Varicella:	2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease. 28 days between doses is acceptable if the doses have already been administered.
Hepatitis A:	2 doses given six calendar months apart, 1st dose on or after 1st birthday
Hib:	1 dose on or after 1st birthday for children less than 5 years old
Pneumococcal:	1 dose on or after 1st birthday for children less than 5 years old

GRADES 1-6

Hep B:	3 doses, last dose on or after 24 weeks of age
DTaP/Td:	At least 4 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses.
Polio:	At least 3 doses. The last dose must be given on or after 4th birthday
MMR:	2 doses separated by at least 28 days, 1st dose on or after 1st birthday
Varicella:	2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease. 28 days between doses is acceptable if the doses have already been administered.
Hepatitis A:	2 doses given six calendar months apart, 1st dose on or after 1st birthday

GRADE 7-10

Hep B:	3 doses, last dose on or after 24 weeks of age
Tdap/Td:	1 dose for students who have completed their primary DTaP series. Students who start the series at age 7 or older only need 3 doses of tetanus-diphtheria containing vaccine, one of which must be Tdap
Polio:	At least 3 doses. The last dose must be given on or after 4th birthday
MMR:	2 doses separated by at least 28 days, 1st dose on or after 1st birthday
Varicella:	2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease. 28 days between doses is acceptable if the doses have already been administered.
Hepatitis A:	2 doses given six calendar months apart, 1st dose on or after 1st birthday
Meningococcal:	1 dose

Revised 1/21//2022

GRADES 11-12	Hep B:	3 doses, last dose on or after 24 weeks of age
	Tdap/Td:	1 dose for students who have completed their primary DTaP series. Students who start the series at age 7 or older only need 3 doses of tetanus-diphtheria containing vaccine, one of which must be Tdap
	Polio:	At least 3 doses. The last dose must be given on or after 4th birthday
	MMR:	2 doses separated by at least 28 days, 1st dose on or after 1st birthday
	Varicella:	2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease. 28 days between doses is acceptable if the doses have already been administered.
	Meningococcal:	1 dose

- DTaP vaccine is not administered on or after the 7th birthday.
- Tdap can be given in lieu of Td vaccine for children 7 years and older unless contraindicated.
- Hib is required for all Pre-K and K students less than 5 years of age.
- Pneumococcal Conjugate is required for all Pre-K and K students less than 5 years of age.
- Hep A requirement for school year 2022-2023 applies to all Pre-K through 10th graders born 1/1/07 or later.
- Hep B requirement for school year 2022-2023 applies to all students in grades K-12. Spacing intervals for a valid Hep B series: at least 4 weeks between doses 1 and 2; 8 weeks between doses 2 and 3; at least 16 weeks between doses 1 and 3; dose 3 must be administered at 24 weeks of age or later.
- Second MMR for school year 2022-2023 applies to all students in grades K-12.
- Meningococcal Conjugate requirement for school year 2022-23 applies to all students in grades 7-12
- Tdap requirement for school year 2022-2023 applies to all students in grades 7-12
- If two live virus vaccines (MMR, Varicella, MMRV, Intra-nasal Influenza) are not administered on the same day, they must be separated by at least 28 days (there is no 4 day grace period for live virus vaccines). If they are not separated by at least 28 days, the vaccine administered second must be repeated.
- Lab confirmation of immunity is **only** acceptable for Hep A, Hep B, Measles, Mumps, Rubella, and Varicella.
- **VERIFICATION OF VARICELLA DISEASE:** Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

For the full legal requirements for school entry visit:
https://portal.ct.gov/DPH/Immunizations/Immunization--Laws-and-Regulations

If you are unsure if a child is in compliance, please call the Immunization Program at (860) 509-7929.

New Entrant Definition:

*New entrants are any students who are new to the school district, including **all** preschoolers and all students coming in from Connecticut private, parochial and charter schools located in the same or another community. **All pre-schoolers, as well as all students entering kindergarten**, including those repeating kindergarten, and those moving from any public or private pre-school program, even in the same school district, **are considered new entrants**. The one exception is students returning from private approved special education placements–they are not considered new entrants.

Commonly Administered Vaccines:

Vaccine:	Brand Name:	Vaccine:	Brand Name:
DTaP-IPV-Hib	Pentacel	MMRV	ProQuad
DTaP-HIB	TriHibit	PCV7	Prevnar
HIB-Hep B	Comvax	PCV13	Prevnar 13
DTaP-IPV-Hep B	Pediarix	DTaP-IPV	Kinrix, Quadracel
Hepatitis A	Havrix, Vaqta	Influenza	Fluzone, FluMist, Fluviron, Fluarix, FluLaval
DTap-IPV-Hib-Hep B	Vaxelis		Flucelvax, Afluria