



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

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, licensed pursuant to chapter 378, a physi-

cian assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base 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 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity	<input type="checkbox"/> Black, not of Hispanic origin
Primary Care Provider	<input type="checkbox"/> American Indian/ Alaskan Native	<input type="checkbox"/> White, not of Hispanic origin
	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Asian/Pacific Islander
		<input type="checkbox"/> Other
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	

* 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	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)						Diabetes	Y	N
Any immediate family members have high cholesterol						ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in school**:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

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.	Date
Signature of Parent/Guardian	

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

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

I have reviewed the health history information provided in Part 1 of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

*Height _____ in. / _____ % *Weight _____ lbs. / _____ % BMI _____ / _____ % Pulse _____ *Blood Pressure _____ / _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen			*Postural <input type="checkbox"/> No spinal abnormality <input type="checkbox"/> Spine abnormality: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Referral made		
Genitalia/ hernia					
Skin					

Screenings

*Vision Screening	*Auditory Screening	History of Lead level ≥ 5µg/dL <input type="checkbox"/> No <input type="checkbox"/> Yes	Date
Type: <u>Right</u> <u>Left</u>	Type: <u>Right</u> <u>Left</u>		
With glasses 20/ 20/	<input type="checkbox"/> Pass <input type="checkbox"/> Pass	*HCT/HGB:	
Without glasses 20/ 20/	<input type="checkbox"/> Fail <input type="checkbox"/> Fail	*Speech (school entry only)	
<input type="checkbox"/> Referral made	<input type="checkbox"/> Referral made	Other:	

TB: High-risk group? No Yes PPD date read: _____ Results: _____ Treatment: _____

*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 the Asthma Action Plan to School

Anaphylaxis No Yes: Food Insects Latex Unknown source
Allergies *If yes, please provide a copy of the Emergency Allergy Plan to School*
 History of Anaphylaxis No Yes Epi Pen required No Yes

Diabetes No Yes: Type I Type II **Other Chronic Disease:** _____

Seizures No Yes, type: _____

This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
 Explain: _____

Daily Medications (specify): _____

This student may: **participate fully in the school program**
 participate in the school program with the following restriction/adaptation: _____

This student may: **participate fully in athletic activities and competitive sports**
 participate in athletic activities and competitive sports with the following restriction/adaptation: _____

Yes No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
 Is this the student's medical home? Yes No I would like to discuss information in this report with the school nurse.

Signature of health care provider MD / DO / APRN / PA	Date Signed	Printed/Stamped Provider Name and Phone Number
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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	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination Completed by: <input type="checkbox"/> Dentist	Visual Screening Completed by: <input type="checkbox"/> MD/DO <input type="checkbox"/> APRN <input type="checkbox"/> PA <input type="checkbox"/> Dental Hygienist	Normal <input type="checkbox"/> Yes <input type="checkbox"/> Abnormal (Describe) _____ _____ _____ _____	Referral Made: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Risk Assessment <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	Describe Risk Factors <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none; vertical-align: top;"> <input type="checkbox"/> Dental or orthodontic appliance <input type="checkbox"/> Saliva <input type="checkbox"/> Gingival condition <input type="checkbox"/> Visible plaque <input type="checkbox"/> Tooth demineralization <input type="checkbox"/> Other _____ </td> <td style="width: 33%; border: none; vertical-align: top;"> <input type="checkbox"/> Carious lesions <input type="checkbox"/> Restorations <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____ </td> </tr> </table>			<input type="checkbox"/> Dental or orthodontic appliance <input type="checkbox"/> Saliva <input type="checkbox"/> Gingival condition <input type="checkbox"/> Visible plaque <input type="checkbox"/> Tooth demineralization <input type="checkbox"/> Other _____	<input type="checkbox"/> Carious lesions <input type="checkbox"/> Restorations <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____
<input type="checkbox"/> Dental or orthodontic appliance <input type="checkbox"/> Saliva <input type="checkbox"/> Gingival condition <input type="checkbox"/> Visible plaque <input type="checkbox"/> Tooth demineralization <input type="checkbox"/> Other _____	<input type="checkbox"/> Carious lesions <input type="checkbox"/> Restorations <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Trauma <input type="checkbox"/> 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
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Immunization Record

To the Health Care Provider: Please complete and initial below.

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/DTaP	*	*	*	*		
DT/Td						
Tdap	*					Required 7th-12th grade
IPV/OPV	*	*	*			
MMR	*	*				Required K-12th grade
Measles	*	*				Required K-12th grade
Mumps	*	*				Required K-12th grade
Rubella	*	*				Required K-12th grade
HIB	*					PK and K (Students under age 5)
Hep A	*	*				See below for specific grade requirement
Hep B	*	*	*			Required PK-12th grade
Varicella	*	*				Required K-12th grade
PCV	*					PK and K (Students under age 5)
Meningococcal	*					Required 7th-12th grade
HPV						
Flu	*					PK students 24-59 months old – given annually
Other						

Disease Hx _____ (Date) _____ (Confirmed by) _____
of above (Specify)

<p>Religious Exemption: _____</p> <p>Religious exemptions must meet the criteria established in Public Act 21-6: https://portal.ct.gov/-/media/SDE/Digest/2020-21/CSDE-Guidance---Immunizations.pdf.</p>	<p>Medical Exemption: _____</p> <p>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</p>
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KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**

GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.

HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade
- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through 11th grade
- August 1, 2024: Pre-K through 12th grade

**** Verification of disease:** Confirmation in writing by an MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

Note: The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nationwide shortage of supply for such vaccine.

Initial/Signature of health care provider MD / DO / APRN / PA	Date Signed	Printed/Stamped <i>Provider</i> Name and Phone Number
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New Milford Public Schools
Pupil's Health History

Date _____

Child's Name (include "nickname") _____ Sex _____ Birth date _____

Home Address _____ Mailing address (if different from home address) _____

Parent/Guardian Names:	Mailing address if different from your home address	Home phone #	Work phone #	Cell #
Mother's Name:				
Father's Name:				
Guardian name - if applicable				
Step parent name -if applicable				

Child lives with: Mother & Father / Mother / Father / Mother or Father & Step-parent / Guardian

Does your child have health insurance? Please circle: YES NO

Child's primary Physician: _____ Phone # _____ Address _____

Dentist _____ Phone # _____ Address _____

Child's Health History *If any of these conditions exist, please describe (include symptoms, dates, treatments, surgical procedures, Medications used, limitations, etc). Use reverse side if needed.*

Life Threatening Allergies (only those that require Epipen/ Benadryl) - include date of most recent reaction & what happened & treatment:

- Food
- Drug
- Insect

Asthma / triggers / early symptoms/ medications:

Bladder / Bowel:

Cardiac:

Diabetes:

Ears (i.e. tubes in / out):

Environmental Allergies:

Food Intolerance / Sensitivity:

Kidney / Urinary:

Current Medications if applicable:

Musculoskeletal:

Neurological (Epilepsy/ Seizures):

Skin (i.e. Birthmarks, Eczema, Mongolian spots):

Surgical Procedures:

Vision: Does child wear glasses? (circle one) Distance only / Reading only / At all times

Examining physician:

Date of last exam:

Diagnosis:

Other Concerns (i.e. developmental, speech):

**New Milford Public Schools
Tuberculosis (TB) Risk Assessment Questionnaire**

Name _____ **Grade** _____

Parents of students new to New Milford Public Schools are required to complete TB Risk Assessment Questionnaire prior to school entry. Parents of students in Kindergarten, Grade 6 and Grade 9 should fill out TB Risk Assessment Questionnaire to be reviewed by student's Physician when student is seen for mandated physical exam.

Please answer the following questions yes or no:

1. **Was your child born outside the US?** _____

If born in any of the countries in the attached list, a TST* or IGRA* should be performed. (Note IGRA's are not recommended for children <5 years old)

2. **Has your child traveled outside the US?** _____

If the child traveled to any of the listed countries, stayed for > 1 week and interacted with the local population, including local family or friends, then a TST or IGRA should be performed. For most children, testing, after evaluation for possible signs and symptoms of TB disease or exposure to a person with contagious pulmonary TB, can take place 8-10 weeks after return to the United States.

3. **Has your child been exposed to anyone with TB disease?** _____

If yes, determine whether the person had TB disease or latent TB infection, when the exposure occurred and what the nature of the contact was. If it is confirmed that the person had known or suspected TB disease, a TST or IGRA should be performed.

4. **Does your child have close contact with someone with a positive TB skin test?** _____

If yes, see previous question for follow-up information needed

5. **Does your child live with anyone who has been in jail or prison, a shelter, who injects illegal drugs, or has HIV?** _____

If yes, then a TST or IGRA should be performed.

6. **Has your child eaten unpasteurized cheese from Mexico or Central America since their last TST or IGRA?** _____

If yes, a TST or IGRA should be performed.

Parent Signature _____ Date _____

*TST- Tuberculin Skin Test

*IGRA-Interferon-gamma release assay (blood test)

Any student who is identified as having a positive reaction to TST or IGRA shall present a letter from the physician stating that a chest x-ray has been administered and student is free from active Tuberculosis prior to school entry.

TB Risk Assessment Questionnaire submitted to school nurse.

4/13 LH