



# 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		
Does your child have dental 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	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
<b>Family History</b>						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)			Y    N			Diabetes	Y	N
Any immediate family members have high cholesterol			Y    N			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.	Signature of Parent/Guardian	Date
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**To be maintained in the student's Cumulative School Health Record**

## Part 2 — Medical Evaluation

HAR-3 REV. 1/2022

### 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"/> Fail		
Without glasses 20/ 20/	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	*HCT/HGB:	
<input type="checkbox"/> Referral made	<input type="checkbox"/> Referral made	*Speech (school entry only)	
		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

<b>Dental Examination</b> Completed by: <input type="checkbox"/> Dentist	<b>Visual Screening</b> Completed by: <input type="checkbox"/> MD/DO <input type="checkbox"/> APRN <input type="checkbox"/> PA <input type="checkbox"/> Dental Hygienist	<b>Normal</b> <input type="checkbox"/> Yes <input type="checkbox"/> Abnormal (Describe) _____ _____ _____ _____	<b>Referral Made:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Risk Assessment</b> <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	<b>Describe Risk Factors</b> <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> <td style="width: 33%; border: none;"></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 <i>Provider</i> Name and Phone Number
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Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

HAR-3 REV. 1/2022

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

Disease Hx \_\_\_\_\_  
of above (Specify) (Date) (Confirmed by)

<p><b>Religious Exemption:</b> _____</p> <p>Religious exemptions must meet the criteria established in <b>Public Act 21-6: <a href="https://portal.ct.gov/-/media/SDE/Digest/2020-21/CSDE-Guidance---Immunizations.pdf">https://portal.ct.gov/-/media/SDE/Digest/2020-21/CSDE-Guidance---Immunizations.pdf</a></b>.</p>	<p><b>Medical Exemption:</b> _____</p> <p>Must have signed and completed medical exemption form attached. <b><a href="https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf">https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf</a></b></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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# STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

## IMMUNIZATION REQUIREMENTS FOR ENROLLED STUDENTS IN CONNECTICUT SCHOOLS 2024-2025 SCHOOL YEAR



### PRESCHOOL

Hepatitis 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 1 <sup>st</sup> birthday
Varicella:	1 dose on or after 1 <sup>st</sup> birthday or verification of disease
Hepatitis A:	2 doses given six calendar months apart, 1 <sup>st</sup> dose on or after 1 <sup>st</sup> birthday
Hib:	1 dose on or after 1 <sup>st</sup> birthday
Pneumococcal:	1 dose on or after 1 <sup>st</sup> birthday
Influenza:	1 dose administered each year between August 1 <sup>st</sup> -December 31 <sup>st</sup> (2 doses separated by at least 28 days required for those receiving flu for the first time)

### KINDERGARTEN

Hepatitis 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 4 <sup>th</sup> birthday
Polio:	At least 3 doses. The last dose must be given on or after 4 <sup>th</sup> birthday
MMR:	2 doses separated by at least 28 days, 1 <sup>st</sup> dose on or after 1 <sup>st</sup> birthday
Varicella:	2 doses separated by at least 3 months-1 <sup>st</sup> dose on or after 1 <sup>st</sup> 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, 1 <sup>st</sup> dose on or after 1 <sup>st</sup> birthday
Hib:	1 dose on or after 1 <sup>st</sup> birthday for children less than 5 years old
Pneumococcal:	1 dose on or after 1 <sup>st</sup> birthday for children less than 5 years old

### GRADES 1-6

Hepatitis 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 4 <sup>th</sup> 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 4 <sup>th</sup> birthday
MMR:	2 doses separated by at least 28 days, 1 <sup>st</sup> dose on or after 1 <sup>st</sup> birthday
Varicella:	2 doses separated by at least 3 months-1 <sup>st</sup> dose on or after 1 <sup>st</sup> 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, 1 <sup>st</sup> dose on or after 1 <sup>st</sup> birthday

### GRADE 7-12

Hepatitis 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 4 <sup>th</sup> birthday
MMR:	2 doses separated by at least 28 days, 1 <sup>st</sup> dose on or after 1 <sup>st</sup> birthday
Varicella:	2 doses separated by at least 3 months-1 <sup>st</sup> dose on or after 1 <sup>st</sup> 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, 1 <sup>st</sup> dose on or after 1 <sup>st</sup> birthday
Meningococcal:	1 dose

- DTaP vaccine is not administered on or after the 7<sup>th</sup> birthday.
- Tdap can be given in lieu of Td vaccine for children 7 years and older unless contraindicated.
- Hib is NOT required once a student turns 5 years of age.
- Pneumococcal conjugate is NOT required once a student turns 5 years of age.
- Influenza is NOT required once a student turns 5 years of age.
- HepA requirement for school year 2024–2025 applies to all Pre-K through 12<sup>th</sup> graders born 1/1/07 or later.
- HepB requirement for school year 2024–2025 applies to all students in grades K–12.  
Spacing intervals for a valid HepB 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 2024–2025 applies to all students in grades K–12.
- Meningococcal conjugate requirement for school year 2024–25 applies to all students in grades 7–12.
- Tdap requirement for school year 2024–2025 applies to all students in grades 7–12.
- If two live virus vaccines (MMR, varicella, MMRV, intranasal 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 HepA, HepB, 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: [Laws and Regulations \(ct.gov\)](#)

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 preschoolers, 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.

Vaccines supplied by the State of Connecticut are listed [here](#), along with brand names.