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

<table>
<thead>
<tr>
<th>Name of Child (Last, First, Middle)</th>
<th>Social Security Number</th>
<th>Birth Date</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (Street)</td>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Town and ZIP code)</td>
<td>American Indian</td>
<td>White, not of Hispanic origin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Asian</td>
<td>Hispanic/Latino</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Black, not of Hispanic origin</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Parent/Guardian (Last, First, Middle)</td>
<td>Home Phone Number</td>
<td>Work/Cell Phone Number</td>
<td></td>
</tr>
<tr>
<td>Early Childhood Program</td>
<td>Preferred Hospital</td>
<td>Health Insurance Company/Number* or Medicaid/Number*</td>
<td></td>
</tr>
</tbody>
</table>

* 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. Do you have any concerns about your child’s general health, development or behavior?

2. Has your child been diagnosed with any chronic disease
   - asthma
   - diabetes
   - seizure disorder
   - other _______________

3. Does your child have any allergies (food, insects, medication, latex, etc.)? Please specify: _______________

4. Does your child take any medications (daily or occasionally)?

5. Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)?

6. Has your child had any hospitalization, operation, major illness or injury, or significant accident?

7. In the last 12 months, has your child experienced any difficulty with wheezing or excessive night coughing?

8. In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination?

9. Has your child had a dental examination in the last 12 months?

10. 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 ____________

ED191 REV. 8/2004 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)

To be maintained in the child’s Health Record
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

BLOOD PRESSURE

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)

Dose 1

Dose 2

Dose 3

Dose 4

Dose 5

Dose 6

ình

DTP

DTP/Hib

DTaP

DT/Td

OPV

IPV

MMR

Measles

Mumps

Rubella

HIB

Hep B

Varicella

PCV

Pneumococcal conjugate vaccine

Other Vaccines (Specify)

Date

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

☐ 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.

☐ Yes

☐ No

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

Address:

☐ Yes

☐ No

This is the child’s Medical Home?

Next Appointment (mm/yy):

Next Immunization Appointment (mm/yy):