



# 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

Name of Child (Last, First, Middle)	Social Security No.	Birth Date	Sex
Address (Street)	Home Telephone Number		
(Town and Zip Code)	Early Childhood Program	Program Number	
Parent/Guardian (Last, First, Middle)	Home Telephone Number	Work Telephone Number	
Medicaid Number*	Health Insurance Company/Number*		

\* 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.  | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any concerns about your child's general health (eating and sleeping habits, weight, teeth, etc.)?   |
| 2.  | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any concerns about your child's development or behavior?  |
| 3.  | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any allergies (food, insects, medication, etc.)?   |
| 4.  | <input type="checkbox"/> | <input type="checkbox"/> | Does your child take any medication (daily or occasionally)?  |
| 5.  | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)?  |
| 6.  | <input type="checkbox"/> | <input type="checkbox"/> | Has your child had any hospitalization, operation, or major illness (specify problem)?                          |
| 7.  | <input type="checkbox"/> | <input type="checkbox"/> | Has your child had any significant injury or accident (specify problem)?  |
| 8.  | <input type="checkbox"/> | <input type="checkbox"/> | Is your child receiving any special services?   |
| 9.  | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any other specific illness or problem?   |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Would you like to discuss anything about your child's health with the child care provider or health consultant? |

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

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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  
 To be maintained in Child's Health Record

\_\_\_\_\_  
 Date

**Part II - Health Evaluation**

**To the Health Care Provider: Please complete all sections and sign. Explain any screenings required by age but not conducted.**

\_\_\_\_\_ has had a complete history and physical exam on \_\_\_\_\_  
 Child's Name Birth Date Month/Day/Year

**HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CARE, SPECIAL DIET, AND EMERGENCIES:** NONE

NONE

**ALLERGIES TO FOOD, MEDICINE, OR INSECTS:**

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE <sup>1</sup>	BLOOD PRESSURE <sup>2</sup>
IN/CM %ILE	LB/KG %ILE	IN/CM %ILE	/

PHYSICAL EXAMINATION	NORMAL	ABNORMAL/COMMENTS
HEAD / EARS / EYES / NOSE / THROAT		
TEETH		
CARDIORESPIRATORY		
ABDOMEN / GI		
GENITALIA / BREASTS		
EXTREMITIES / JOINTS / BACK / CHEST		
SKIN / LYMPH NODES		
NEUROLOGIC / TONE		
DEVELOPMENT		

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTP/DtaP						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
PNEUMOCOCCAL						
OTHER						

**Disease Hx of above or contagious disease** \_\_\_\_\_ (specify) \_\_\_\_\_ (date) \_\_\_\_\_ (Confirmed by)

**Exemption** Religious: \_\_\_\_\_ Medical: \_\_\_\_\_ Permanent: \_\_\_\_\_ Temporary: \_\_\_\_\_ Date: \_\_\_\_\_

SCREENING TESTS	RESULTS	DATE	ABNORMAL/COMMENTS
VISION (Type of Screening _____) <sup>2</sup>			
HEARING (Type of Screening _____) <sup>3</sup>			
LEAD <sup>4</sup>			
ANEMIA (HGB/HCT) <sup>4</sup>			
URINALYSIS (UA) <sup>5</sup>			
TB (Risk? Yes / No) <sup>5</sup>			
DEVELOPMENTAL ASSESSMENT <sup>6</sup>			
DATE OF LAST DENTIST'S EXAMINATION <sup>7</sup>			

**Minimum requirements:** <sup>1</sup> Up to 2 years; <sup>2</sup> annual at 3 years; <sup>3</sup> annual at 4 years; <sup>4</sup> 9 – 12 months, 2 years <sup>5</sup> as needed; <sup>6</sup> each visit through 5 yrs; <sup>7</sup> annual at 2 – 3 years  
**Prior to public school entry:** Same as above and Hgb/hct

This child has the following conditions which may affect the educational experience:  
 Vision  Auditory  Speech/Language  Physical Dysfunction  Emotional/Social  Behavior

Re: Licensing: Does this child have 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

This child has a health condition which may require emergency action at school, e.g., seizures, allergies, asthma. *Specify below.*  
 The child is on long-term or emergency medication. *Specify below.*

Comments and recommendations (attach additional sheet if necessary): \_\_\_\_\_

This child may participate fully in the early childhood program.  
 This child may participate in the early childhood program with the following restriction/adaptation: *(Specify reason and restriction)*

Yes  No Based on this comprehensive health history and physical examination, this child has maintained his/her level of wellness.  
 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:			Next Appointment: (Mo/Yr): Next Appointment for Immunization (Mo/Yr):