_____ 100 Mona Terrace, Fairfield, Ct. 06824 _____ 20 Ivy Brook Road, Shelton, Ct. 06484

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

Name of Child (Last, First, Middle)	Social Security Number	Birth Date	Sex

Address (Street)	Race/Ethnicity
	American Indian / White, not of Hispanic origin
(Town and ZIP code)	Asian / Hispanic/Latino
	Black, not of Hispanic origin / Other

Parent/Guardian (Last, First, Middle)	Home Phone Number	Work/Cell Phone Number

Primary Health Care Provider	Preferred Hospital	Health Insurance Company/Number* or Medicaid/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. 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 urination?
9. H as 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); To be maintained in the child's Health Record
P.H. Code Section 19a-79-5a(a)(2), 19a-87b-10b(2)

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 [1]
IN/CM %ILE	LB/KG %ILE	%ILE	IN/CM %ILE	/

Screening/Test Results

Screening Test	Result	Date	Abnormal/Comments
Vision [2] Test type:			
Hearing Test type			
Lead [4] Risk: Yes/No			
TB [4] Risk: Yes/No			
Urinalysis (UA)[4]			
Anemia [5] (HGB/HCT) Risk: Yes/No			
Developmental [6] **Assessment** Test type:			

Immunization Record

Vaccine (Month/Day/Year)	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP						
DTP/Hib						
DTaP						
DT/Td						
OPV						
IPV						
MMR						
Measles						
Mumps						
Rubella						
HIB						
Hep B						
Varicella						
PCV						Pneumococcal conjugate vaccine

***Chronic Disease Assessment:** Date of Onset

Yes No

□ □ **Asthma**: □ mild □ moderate □severe □ exercise induced □ unclassified _____

□ □ **Diabetes**: □ Type I □ Type II _____

□ □ **Anaphylaxis:**□ med.□ food □ insect □ latex _____

□ □ **Seizures**: Type _____ _____

□ □ **Other: Please specify** _____ _____

Has this child received dental care in the lasst 12 months ? □ Yes □ No □ N/A

Other Vaccines (Specify)

1. _____ 2. _____ 3._____ 4. _____ 5. _____ 6._____
7. _____ 8. _____ 9._____ 10. _____11. _____12._____

Minimum requirements: [1] Up to 2 years; [2] annual at 3 years; [3] annual at 4 years; [4] as needed; [5] 9–12 months; [6] each visit through 5 years; [7] annual at 2–3 years. Federal requirements (eg, Head Start, WIC) may vary.*Prior to Public School Entry: Same as above and Hgb/hct.

Disease Hx of above _____ (Specify) _____ (Date mm/yy) _____ (Confirmed by)

Exemption

Religious _____ **Medical: Permanent** _____ **Temporary** _____ **Date** _____

Recertify Date _____ Recertify Date _____ Recertify Date _____

Next Appointment (mm/yy)	Next Immunization Appointment (mm/yy)

This child has the following problems which may adversely affect his or her educational experience: □Vision □ Auditory □Speech/Language □ Physical Dysfunction □ Emotional/Social □ Behavior The child has a health condition which may require intervention at the program, e.g., seizures, allergies, asthma, anaphylaxis, special diet, long-term medication.

*Specify:*_____

_____

□ 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.

□ The child may fully participate in the program.

□ The child may fully participate in the program with the following

□ I would like to discuss informaiton 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 Is this the child's medical Home?