

**PLAYLAND NURSERY SCHOOL**

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**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		
(Town and ZIP code)		<input type="checkbox"/> American Indian	<input type="checkbox"/> White, not of Hispanic origin	
		<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic/Latino	
		<input type="checkbox"/> Black, not of Hispanic origin	<input type="checkbox"/> Other	
Parent/Guardian (Last, First, Middle)		Home Phone Number	Work/Cell Phone Number	
Early Childhood Program			Program 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 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

## 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 <sup>1</sup>		BLOOD PRESSURE <sup>2</sup>
IN/CM	%ILE	LB/KG	%ILE	%ILE	IN/CM	%ILE	/

### Screening/Test Results

Screening Test	Result	Date	Abnormal/Comments
<b>Vision<sup>2</sup></b> Test type: _____			
<b>Hearing<sup>3</sup></b> Test type: _____			
<b>Lead<sup>4</sup></b> Risk: Yes/No			
<b>TB<sup>4</sup></b> Risk: Yes/No			
<b>Urinalysis (UA)<sup>4</sup></b>			
<b>Anemia<sup>5</sup></b> (HGB/HCT) Risk: Yes/No			
<b>Developmental Assessment<sup>6</sup></b> 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

Has this child received dental care in the last 12 months?<sup>7</sup>  Yes  No  N/A

**\* Chronic Disease Assessment:**

Yes No Date of onset

Asthma:  mild  moderate  severe  
 exercise induced  unclassified

Diabetes:  Type I  Type II

Anaphylaxis:  med.  food  insect  latex

Seizures: Type \_\_\_\_\_

Other: Please specify \_\_\_\_\_

#### Other Vaccines (Specify)

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**Disease Hx of above** \_\_\_\_\_  
 (Specify) (Date mm/yy) (Confirmed by)

#### Exemption

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

Recertify Date \_\_\_\_\_ Recertify Date \_\_\_\_\_ Recertify Date \_\_\_\_\_

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>as needed; <sup>5</sup>9-12 months; <sup>6</sup>each visit through 5 years; <sup>7</sup>annual at 2-3 years.  
 Federal requirements (eg, Head Start, WIC) may vary.  
 \*Prior to Public School Entry: Same as above and Hgb/hct.

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 restrictions/adaptation: (Specify reason and restriction.) \_\_\_\_\_
- 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
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Address: \_\_\_\_\_

Yes  No Is this the child's Medical Home? Next Appointment (mm/yy): \_\_\_\_\_ Next Immunization Appointment (mm/yy): \_\_\_\_\_