



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) Susie Softball		Birth Date 7.11.2006	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, Town and ZIP code) 2 High St Fairfield CT			
Parent/Guardian Name (Last, First, Middle)		Home Phone	Cell Phone 203-111-2222
School/Grade	Race/Ethnicity	<input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other	
Primary Care Provider	<input type="checkbox"/> American Indian/ Alaskan Native <input type="checkbox"/> Hispanic/Latino		
Health Insurance Company/Number* or Medicaid/Number*			
Does your child have health insurance? Y N		If your child does not have health insurance, call 1-877-CT-HUSKY	
Does your child have dental insurance? Y N			

* 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
Family History				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

Sharon Softball 9.2.2020

Part 2 — Medical Evaluation

HAR-3 REV. 7/2018

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name Susie Softbael Birth Date 7.11.2006 Date of Exam 9.2.2020

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> With glasses 20/ 20/ Without glasses 20/ 20/ <input type="checkbox"/> Referral made	Type: <u>Right</u> <u>Left</u> <input type="checkbox"/> Pass <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Fail <input type="checkbox"/> Referral made	*HCT/HGB: *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 <u>De Jones MD</u>	Date Signed <u>9.2.2020</u>	Printed/Stamped Provider Name and Phone Number
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