Departamento de Educación del estado de Connecticut

Registro de la evaluación de salud de la niñez temprana

Al Padre, la madre o el tutor:

Para poder brindarle el mejor servicio, los proveedores de atención médica de la niñez temprana deben entender las necesidades de salud de su hijo. En la primera parte de este formulario le pedimos información sobre la salud de su hijo. Ésta ayudará a los médicos para su evaluación (Parte II). Antes de poder ingresar a un Programa de la Niñez Temprana, la ley del estado requiere que un médico, enfermera de práctica avanzada, asociado médico, profesional de la salud certificado legalmente o un asociado médico asignado a una base militar realice una evaluación de salud y le haya puesto las vacunas principales Connecticut (C.G.S. Secs. 10-204a and 10-206). Una revisión de inmunización y evaluaciones de salud adicionales son necesarias en el 6° o 7° grado y en el noveno o décimo grado. El grado específico será determinado por la junta local de educación. Este formulario también puede ser utilizado para las evaluaciones de salud necesarias cada año para los estudiantes que vayan a participar en los equipos deportivos.

Por favor escriba en letra de imprenta

Nombre del Estudiante (apellido, nombre, segundo nombre)	Fecha de Nacimiento	☐Niño ☐Niña
Dirección (calle, poblado y código postal)		
Nombre del padre, la madre o tutor (apellido,nombre, 2do nombre)	Teléfono de la casa	Teléfono celular
Escuela/ Grado	Raza/ Procedencia étnico ☐Nativo americano/ o de Alaska	☐Negro, no de origen hispano ☐Blanco no de origen hispano ☐Asiático/ Islas del Pacifico
Médico de cabecera	☐Hispano/Latino	☐Otro
Compañía de seguro médico/Número* o Medicaid/Número*		

¿Su hijo tiene seguro médico? S N
¿Su hijo tiene seguro dental? S N

Si su hijo no tiene seguro medico, llame al **1-877-CT-HUSKY**

* Si aplica

Parte I — El padre, la madre o el tutor legal debe llenar esta parte.

Antes del examen físico, por favor conteste las siguientes preguntas acerca de la salud de su hijo(a).

Encierre en un círculo la **S** si la respuesta es "sí" o la **N** si la respuesta es "no".
En el espacio que aparece a continuación, ofrezca una explicación a todas las peguntas a las que contestó "sí".

Alguna inquietud sobre la salud	S	N	Hospitalización o Visitas a la sala de emergencias	S	N	Contusión cerebral	S	N
Alergia de comida, picaduras de insectos	S	N	Hueso roto o dislocado	S	N	Se ha desmayado	S	N
Alergia a algún medicamento	S	N	Herida de musculo o coyuntura	S	N	Dolor en el pecho	S	N
Alguna otra alergia	S	N	Herida al cuello o la espalda	S	N	Algún problema del corazón	S	N
Toma medicamentos diariamente	S	N	Problema cuando corre	S	N	Presión sanguínea alta	S	N
Alguna dificultad con la visión	S	N	"Mono" (en el último año)	S	N	Sangrando más de lo normal	S	N
Usa lentes de contacto o anteojos	S	N	Tiene un riñón o testículo	S	N	Dificultad con la respiración o tiene tos	S	N
Alguna dificultad con la audición	S	N	Aumentó o bajó de peso en exceso	S	N	Ha fumado	S	N
Alguna dificultad del habla	S	N	Frenillos, capas o puentes dentales	S	N	Tratamientos para el asma (últimos 3 años)	S	N
Historial Familiar						Tratamiento de convulsiones (últimos 2 años)	S	N
Algún pariente ha tenido una repentina muerte inexplicable (menos de 50 años)				S	N	Diabetes	S	N
Algún miembro de la familia inmediata tiene el colesterol alto				S	N	ADHD/ADD	S	N

Si respondió "Sí" a alguna de las preguntas, explique su respuesta o proporcione información adicional. Para las heridas e enfermedades favor de incluir el año y la edad del niño cuando pasó:

¿Hay algo que quieres discutir con la enfermera escolar? S N Si la respuesta es "Si", explique:

Por favor apunte el nombre de cualquier **medicamento** que su hijo tendrá que tomar mientras asiste al programa:

En caso de que sea necesario administrar algún medicamento durante el Programa, el medico que le recetó el medicamento y el padre, la madre o el tutor legal deben firmar una autorización adicional llamada ***Medication Authorization Form*** *(formulario de autorización para administrar medicamentos.*

Por este medio doy autorización al médico de mi hijo y al profesional de la niñez temprana o al asesor/enfermera/coordinador de salud a que compartan, confidencialmente, la información de este formulario, para cubrir las necesidades educativas y de salud de mi hijo(a) en el programa de la niñez temprana.

Firma del padre, la madre o del tutor Fecha

Para mantenerse en el archivo de salud del estudiante

Part 2 — Medical Evaluation

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

Student Name ______________________ Birth Date ____________ Date of Exam ____________

❑ 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** ❑ No spinal abnormality	❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made	
Genitalia/ hernia					
Skin					

Screenings

***Vision Screening**

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Referral made

***Auditory Screening**

Type:	Right	Left
	❑ Pass ❑ Fail	❑ Pass ❑ Fail

❑ Referral made

	Date
History of Lead level ≥ 5µg/dL ❑ No ❑ Yes	
***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 Allergies ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source
*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 MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	❑ Male ❑ Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	**Visual Screening**	**Normal**	**Referral Made:**
Completed by: ❑ Dentist	Completed by: ❑ MD/DO ❑ APRN ❑ PA ❑ Dental Hygienist	❑ Yes ❑ Abnormal (Describe) __________ __________ __________ __________ __________	❑ Yes ❑ No
Risk Assessment	**Describe Risk Factors**		
❑ Low ❑ Moderate ❑ High	❑ Dental or orthodontic appliance ❑ Saliva ❑ Gingival condition ❑ Visible plaque ❑ Tooth demineralization ❑ Other __________	❑ Carious lesions ❑ Restorations ❑ Pain ❑ Swelling ❑ Trauma ❑ Other __________	

Recommendation(s) by health care provider: ______________________________

____

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

____

Signature of health care provider DMD / DDS / MD / DO / APRN / PA/ RDH Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Student Name: ______________________ **Birth Date:** ______________ HAR-3 REV. 1/2022

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap	*				Required 7th-12th grade	
IPV/OPV	*	*	*			
MMR	*	*			Required K-12th grade	
Measles	*	*			Required K-12th grade	
Mumps	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*				PK and K (Students under age 5)	
Hep A	*	*			See below for specific grade requirement	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			Required K-12th grade	
PCV	*				PK and K (Students under age 5)	
Meningococcal	*				Required 7th-12th grade	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

Disease Hx of above ______________ (Specify) ______________ (Date) ______________ (Confirmed by)

Religious Exemption: ________

Religious exemptions must meet the criteria established in Public Act 21-6: https://portal.ct.gov/-/media/SDE/Digest/2020-21/CSDE-Guidance---Immunizations.pdf.

Medical Exemption: ________

Must have signed and completed medical exemption form attached. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf

KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the1st birthday or verification of disease.**

GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.

HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade
- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through11th grade
- August 1, 2024: Pre-K through 12th grade

** **Verification of disease:** Confirmation in writing by an MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

Note: The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nationwide shortage of supply for such vaccine.

Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number