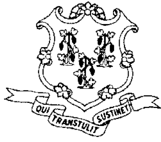

Departamento de Educación del Estado de Connecticut
Registro de Evaluación de Salud

Al padre/madre o tutor:

A fin de proporcionar la mejor experiencia educativa, el personal de la escuela debe comprender las necesidades de salud de su hijo. Este formulario solicita información de usted (Parte 1) que también será útil para el proveedor de atención médica cuando complete la evaluación médica (Parte 2) y la evaluación oral (Parte 3).

La ley estatal requiere las vacunas primarias completas y una evaluación de salud de un profesional de medicina legalmente calificado, una enfermera registrada de práctica avanzada o una enfermera registrada, con una licencia otorgada conforme al capítulo 378, un asistente del médico, con licencia otorgada conforme al capítulo 370, un asesor médico escolar o un profesional de medicina legalmente calificado, una enfermera registrada de práctica avanzada o un asistente del médico asignado a una base militar antes del ingreso a la escuela en Connecticut (C.G.S. Secciones 10-204a y 10-206). Se requiere una actualización de las vacunas y evaluaciones adicionales de salud en 6.º o 7.º grado y en 9.º o 10.º grado. La junta local de educación determinará el nivel del grado específico. Este formulario también puede utilizarse para las evaluaciones de salud requeridas todos los años para los estudiantes que participan en equipos deportivos.

Por favor, complete en letra de molde

Nombre del estudiante (Apellido, primer nombre, segundo nombre)	Fecha de nacimiento	❑ Masculino ❑ Femenino
Dirección (Calle, ciudad y código postal)		
Nombre del padre/madre/tutor (Apellido, primer nombre, segundo nombre)	Teléfono residencial	Teléfono celular
Escuela/Grado	Raza/origen étnico ❑ Indio americano / Nativo de Alaska ❑ Hispano/Latino	❑ Negro, no de origen hispano ❑ Blanco, no de origen hispano ❑ Asiático/Nativo de una isla del Pacífico ❑ Otro
Proveedor de atención primaria		
Empresa de seguro de salud/Número* o Medicaid/Número*		

¿Su hijo tiene seguro de salud? S N
¿Su hijo tiene seguro dental? S N

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

* Si corresponde

Parte 1— Debe completarla el padre/madre/tutor.
Responda estas preguntas sobre los antecedentes de salud sobre su hijo antes del examen físico.

Marque **S** para "sí" o **N** para "no". Explique todas las respuestas afirmativas en el espacio proporcionado a continuación.

Problemas de salud	S	N	Hospitalización o entradas a Sala de Emergencia	S	N	Contusión	S	N
Alergias a alimentos o picaduras de abejas	S	N	Fracturas de huesos o dislocaciones	S	N	Desmayos o pérdidas de la conciencia	S	N
Alergias a medicamentos	S	N	Lesiones musculares o en las articulaciones	S	N	Dolor en el pecho	S	N
Otras alergias	S	N	Lesiones en el cuello o la espalda	S	N	Problemas cardíacos	S	N
Medicamentos diarios	S	N	Problemas para correr	S	N	Presión arterial alta	S	N
Problemas con la visión	S	N	Mononucleosis (en el último año)	S	N	Sangrado mayor al esperado	S	N
Usa lentes de contacto o gafas	S	N	Tiene solo 1 riñón o testículo	S	N	Problemas para respirar o tos	S	N
Problemas de audición	S	N	Aumento/pérdida excesiva de peso	S	N	Tabaquismo	S	N
Problemas con el habla	S	N	Ortodoncia, coronas o puentes dentales	S	N	Tratamiento para el asma (últimos 3 años)	S	N
Antecedentes familiares ¿Algún familiar sufrió una muerte inexplicable repentina (menor de 50 años)?				S	N	Tratamiento para convulsiones (últimos 2 años)	S	N
						Diabetes	S	N
Algún familiar directo tiene colesterol alto				S	N	TDAH/TDA	S	N

Explique aquí todas las respuestas afirmativas. Para enfermedades/lesiones/etc., incluya el año o la edad de su hijo en ese momento.

¿Hay algo que desee analizar con la enfermera escolar? S N En caso afirmativo, explique:

Indique los **medicamentos** que deberá tomar su hijo **en** la escuela:

Todos los medicamentos tomados en la escuela requieren un ***formulario de autorización de medicamentos*** *por separado, firmado por un proveedor de atención médica y el padre/madre/tutor.*

Otorgo mi permiso para la divulgación y el intercambio de la información en este formulario entre la enfermera de la escuela y el proveedor de atención médica para su uso confidencial para cubrir las necesidades de salud y educativas de mi hijo en la escuela.

Firma del padre/madre/tutor Fecha

A conservar en el Expediente de Salud Acumulativo de la Escuela 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	❑ Pass
	❑ Fail	❑ 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. 7/2018

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)

Exemption: Religious __________ **Medical:** Permanent __________ Temporary __________ **Date:** __________

Renew Date: ______________ ______________ ______________ ______________

Religious exemption documentation is required upon school enrollment and then renewed at 7th grade entry.
Medical exemptions that are temporary in nature must be renewed annually.

Immunization Requirements for Newly Enrolled Students at Connecticut Schools (as of 8/1/17)

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 through 11th 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