Depatman Edikasyon Eta Connecticut
Dosye Evalyasyon Sante

Pou Paran oswa Titè:

Pou kapab bay pi bon eksperyans edikatif, pèsonèl lekòl la dwe konprann bezwen sante pitit ou a. Fòm sa a mande w enfòmasyon (Pati 1) ki pral itil founisè swen sante a tou lè li fin fè evalyasyon medikal la (Pati 2) ak evalyasyon oral la (Pati 3).

Lwa Eta a egzije vaksen prensipal konplè ak yon evalyasyon sante pa yon doktè ki kalifye legalman nan medsin, yon enfimyè otorize nan pratik avanse oswa yon enfimyè ki agreye, ki gen lisans dapre chapit 378, yon medsen asistan, ki gen lisans dapre chapit 370, yon konseye medikal nan lekòl, oswa yon pratikan medsin ki kalifye legalman, yon enfimyè ki otorize nan pratik avanse oswa yon medsen asistan ki afekte ak yon baz militè anvan antre lekòl nan Connecticut (C.G.S. Secs 10-204a ak 10-206). Yon vaksinasyon ajou ak evalyasyon sante adisyonèl obligatwa nan 6yèm oswa 7yèm ane ak nan 9yèm oswa 10yèm ane. Nivo klas espesifik la ap detèmine pa konsèy edikasyon lokal la. Fòm sa a ka itilize tou pou evalyasyon sante ki nesesè chak ane pou elèv k ap patisipe nan ekip espò yo

Tanpri ekri an lèt detache

Non Elèv la (Siyati, Non, Dezyèm Prenon)	Dat nesans	❑ Gason ❑ Fi
Adrès (Ri, Vil ak kòd postal)		
Non paran/titè (Siyati, Non, Dezyèm Prenon)	Telefòn lakay	Telefòn Selilè
Lekòl/Klas	Ras/Etnisite ❑ Amerendyen/ Natif Alaska ❑ Panyòl/Latino	❑ Nwa, ki pa gen orijin Panyòl ❑ Blan, ki pa gen orijin Panyòl ❑ Azyatik/Zile Pasifik ❑ Lòt
Founisè Swen Prensipal		
Konpayi/Nimewo Asirans Sante* oswa Medicaid/Nimewo*		
Èske pitit ou a gen asirans sante? W N Èske pitit ou a gen asirans dantè? W N	Si pitit ou a pa gen asirans sante, rele **1-877-CT-HUSKY**	

* Si sa aplikab

Pati 1 — Pou Paran/Titè ranpli.
Tanpri reponn kesyon sou istorik sante sa yo konsènan pitit ou a anvan egzamen medikal la.

Tanpri ansèkle **W** si "wi" oswa **N** si "non." Esplike tout repons "wi" yo nan espas ki anba a.

Yon pwoblèm sante	W	N	Ospitalizasyon oswa vizit Sal Ijans	W	N	Komosyon Serebral	W	N
Alèji ak yon manje oswa piki myèl	W	N	Zo kase oswa dislokasyon	W	N	Endispoze oswa pèdi konesans	W	N
Alèji ak yon medikaman	W	N	Blesi nan misk oswa jwenti	W	N	Doulè nan pwatrin	W	N
Nenpòt lòt alèji	W	N	Blesi nan kou oswa nan do	W	N	Pwoblèm kè	W	N
Medikaman pou pran chak jou	W	N	Pwoblèm pou kouri	W	N	Tansyon wo	W	N
Yon pwoblèm vizyon	W	N	"Mono" (1 ane)	W	N	Senyen plis pase sa yo te prevwa	W	N
Itilize lantiy kontak oswa linèt	W	N	Gen sèlman 1 ren oswa testikil	W	N	Pwoblèm pou respire oswa touse	W	N
Pwoblèm pou tande	W	N	Pran/pèt pwa eksesif	W	N	Fimen	W	N
Pwoblèm ak lapawòl	W	N	Aparèy, pwotèz, kouwòn dantè	W	N	Tretman opresyon (3 ane ki sot pase yo)	W	N
Istorik Fanmi						Tretman kriz malkadi (2 ane ki sot pase yo)	W	N
Eske yon fanmi deja mouri toudenkou san rezon (mwens pase 50 lane)				W	N	Dyabèt	W	N
Yon manm fanmi imedya gen kolestewòl wo				W	N	ADHD/ADD	W	N

Tanpri esplike tout repons "wi" yo la a. Pou maladi / blesi / elatriye, edike ane a ak / oswa laj pitit ou a te genyen nan moman an.

Èske gen yon bagay ou vle diskite ak enfimyè lekòl la? W N Si wi, esplike:

Tanpri endike tout **medikaman** pitit ou a pral bezwen pran **nan** lekòl la:

*Tout medikaman ki ap pran nan lekòl la dwe akonpaye de yon **Fòm Otorizasyon pou Medikaman** separe ki siyen pa yon founisè swen sante epi paran/titè.*

Mwen bay pèmisyon pou divilgasyon ak echanj enfòmasyon ki sou fòm sa a ant enfimyè lekòl la ak founisè swen sante a pou itilizasyon konfidansyèl pou reponn ak bezwen sante epi edikasyon pitit mwen nan lekòl la.

Siyati Paran/Titè _____ Dat

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					
Genitalia/ hernia					
Skin					

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

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 ❑ 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 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