



State of Connecticut Department of Education

Early Childhood Health Assessment Record



(For children ages birth – 5)

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 be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

| | | |
|--|---|--|
| Child’s Name (Last, First, Middle) | Birth Date (mm/dd/yyyy) | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Address (Street, Town and ZIP code) | | |
| Parent/Guardian Name (Last, First, Middle) | Home Phone | Cell Phone |
| Early Childhood Program (Name and Phone Number) | Race/Ethnicity <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Other | |
| Primary Health Care Provider: | | |
| Name of Dentist: | | |
| 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 | |
| Does your child have HUSKY insurance? | Y N | |

* If applicable

Part I — 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 | Frequent ear infections | Y | N | Asthma treatment | Y | N |
| Allergies to food, bee stings, insects | Y | N | Any speech issues | Y | N | Seizure | Y | N |
| Allergies to medication | Y | N | Any problems with teeth | Y | N | Diabetes | Y | N |
| Any other allergies | Y | N | Has your child had a dental examination in the last 6 months | Y | N | Any heart problems | Y | N |
| Any daily/ongoing medications | Y | N | | | | Emergency room visits | Y | N |
| Any problems with vision | Y | N | Very high or low activity level | Y | N | Any major illness or injury | Y | N |
| Uses contacts or glasses | Y | N | Weight concerns | Y | N | Any operations/surgeries | Y | N |
| Any hearing concerns | Y | N | Problems breathing or coughing | Y | N | Lead concerns/poisoning | Y | N |
| Developmental — Any concern about your child’s: | | | | | | Sleeping concerns | Y | N |
| 1. Physical development | Y | N | 5. Ability to communicate needs | Y | N | High blood pressure | Y | N |
| 2. Movement from one place to another | Y | N | 6. Interaction with others | Y | N | Eating concerns | Y | N |
| | | | 7. Behavior | Y | N | Toileting concerns | Y | N |
| 3. Social development | Y | N | 8. Ability to understand | Y | N | Birth to 3 services | Y | N |
| 4. Emotional development | Y | N | 9. Ability to use their hands | Y | N | Preschool Special Education | Y | N |

Explain all “yes” answers or provide any additional information:

Have you talked with your child’s primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

*All medications taken in child care programs require a separate **Medication Authorization Form** signed by an authorized prescriber and parent/guardian.*

I give my consent for my child’s health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the 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

Child's Name: _____ Birth Date: _____

Immunization Record

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

Vaccine (Month/Day/Year) _____

| | Dose 1 | Dose 2 | Dose 3 | Dose 4 | Dose 5 | Dose 6 |
|--------------|--------|--------|--------|--------|-----------------------------------|--------|
| DTP/DTaP/DT | | | | | | |
| IPV/OPV | | | | | | |
| MMR | | | | | | |
| Measles | | | | | | |
| Mumps | | | | | | |
| Rubella | | | | | | |
| Hib | | | | | | |
| Hepatitis A | | | | | | |
| Hepatitis B | | | | | | |
| Varicella | | | | | | |
| PCV* vaccine | | | | | *Pneumococcal conjugate vaccine | |
| Rotavirus | | | | | | |
| MCV** | | | | | **Meningococcal conjugate vaccine | |
| Influenza | | | | | | |
| Tdap/Td | | | | | | |

| | |
|--|--|
| Disease history for varicella (chickenpox) _____ | |
| (Date) | (Confirmed by) |
| Exemption: Religious _____ | Medical: Permanent _____ †Temporary _____ Date _____ |
| ‡Recertify Date _____ | ‡Recertify Date _____ ‡Recertify Date _____ |

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

| Vaccines | Under 2 months of age | By 3 months of age | By 5 months of age | By 7 months of age | By 16 months of age | 16-18 months of age | By 19 months of age | 2 years of age (24-35 mos.) | 3-5 years of age (36-59 mos.) |
|---|-----------------------|--------------------|--------------------|--|--|--|--|--|--|
| DTP/DTaP/DT | None | 1 dose | 2 doses | 3 doses | 3 doses | 3 doses | 4 doses | 4 doses | 4 doses |
| Polio | None | 1 dose | 2 doses | 2 doses | 2 doses | 2 doses | 3 doses | 3 doses | 3 doses |
| MMR | None | None | None | None | 1 dose after 1st birthday ¹ | 1 dose after 1st birthday ¹ | 1 dose after 1st birthday ¹ | 1 dose after 1st birthday ¹ | 1 dose after 1st birthday ¹ |
| Hep B | None | 1 dose | 2 doses | 2 doses | 2 doses | 2 doses | 3 doses | 3 doses | 3 doses |
| HIB | None | 1 dose | 2 doses | 2 or 3 doses depending on vaccine given ³ | 1 booster dose after 1st birthday ⁴ | 1 booster dose after 1st birthday ⁴ | 1 booster dose after 1st birthday ⁴ | 1 booster dose after 1st birthday ⁴ | 1 booster dose after 1st birthday ⁴ |
| Varicella | None | None | None | None | 1 dose after 1st birthday or prior history of disease ^{1,2} | 1 dose after 1st birthday or prior history of disease ^{1,2} | 1 dose after 1st birthday or prior history of disease ^{1,2} | 1 dose after 1st birthday or prior history of disease ^{1,2} | 1 dose after 1st birthday or prior history of disease ^{1,2} |
| Pneumococcal Conjugate Vaccine (PCV) | None | 1 dose | 2 doses | 3 doses | 1 dose after 1st birthday | 1 dose after 1st birthday | 1 dose after 1st birthday | 1 dose after 1st birthday | 1 dose after 1st birthday |
| Hepatitis A | None | None | None | None | 1 dose after 1st birthday ⁵ | 1 dose after 1st birthday ⁵ | 1 dose after 1st birthday ⁵ | 2 doses given 6 months apart ⁵ | 2 doses given 6 months apart ⁵ |
| Influenza | None | None | None | 1 or 2 doses | 1 or 2 doses ⁶ | 1 or 2 doses ⁶ | 1 or 2 doses ⁶ | 1 or 2 doses ⁶ | 1 or 2 doses ⁶ |

1. Laboratory confirmed immunity also acceptable
 2. Physician diagnosis of disease
 3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
 4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
 5. Hepatitis A is required for all children born on or after January 1, 2009
 6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

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