ED 191
Rev 08/01
C.G. S. Section 10-16q, 10-206, 19a-79(a), 19a-87b(c); P.H. Code Section 19a-79-5a(a)(2), 19a-87b-10b(2)

Connecticut Early Childhood Health Assessment Record

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

Please print

Name of Child (Last, First, Middle)	Social Security No.	Birth Date	Sex
Address (Street)	Home Telephone Number		
(Town and Zip Code)	Early Childhood Program	Program Number	
Parent/Guardian (Last, First, Middle)	Home Telephone Number	Work Telephone Number	
Medicaid Number*	Health Insurance Company/Number*		

* If applicable

If your child does not have health insurance, call 1-877-CT-HUSKY

Part I - To be completed by parent

Important: Complete Part I before your child is examined.

Take this form with you to the health care provider's office.

Please check answers to the following questions in columns on the left.
(Explain all "yes" answers in the space provided below.)

	Yes	No	
1.	☐	☐	Do you have any concerns about your child's general health (eating and sleeping habits, weight, teeth, etc.)?
2.	☐	☐	Do you have any concerns about your child's development or behavior?
3.	☐	☐	Does your child have any allergies (food, insects, medication, etc.)?
4.	☐	☐	Does your child take any medication (daily or occasionally)?
5.	☐	☐	Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)?
6.	☐	☐	Has your child had any hospitalization, operation, or major illness (specify problem)?
7.	☐	☐	Has your child had any significant injury or accident (specify problem)?
8.	☐	☐	Is your child receiving any special services?
9.	☐	☐	Does your child have any other specific illness or problem?
10.	☐	☐	Would you like to discuss anything about your child's health with the child care provider or health consultant?

(Please explain any "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.)

I give permission for release of 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

To be maintained in Child's Health Record

Part II - Health Evaluation

To the Health Care Provider: Please complete all sections and sign. Explain any screenings required by age but not conducted.

_____ _____ has had a complete history and physical exam on _____

Child's Name **Birth Date** Month/Day/Year

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CARE, SPECIAL DIET, AND EMERGENCIES: NONE ☐

NONE ☐

ALLERGIES TO FOOD, MEDICINE, OR INSECTS:

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE[1]	BLOOD PRESSURE[2]
IN/CM _____ *%ILE*	_____ *LB/KG* _____ *%ILE*	_____ *IN/CM* _____ *%ILE*	_____ / _____

PHYSICAL EXAMINATION	NORMAL	ABNORMAL/COMMENTS
HEAD / EARS / EYES / NOSE / THROAT		
TEETH		
CARDIORESPIRATORY		
ABDOMEN / GI		
GENITALIA / BREASTS		
EXTREMITIES / JOINTS / BACK / CHEST		
SKIN / LYMPH NODES		
NEUROLOGIC / TONE		
DEVELOPMENT		

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTP/DtaP						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
PNEUMOCOCCAL						
OTHER						

Disease Hx of above or contagious disease _____ (specify) _____ (date) _____ (Confirmed by)

Exemption Religious: Medical: Permanent: Temporary: Date:

SCREENING TESTS	RESULTS	DATE	ABNORMAL/COMMENTS
VISION (Type of Screening_____)[2]			
HEARING (Type of Screening_____)[3]			
LEAD[4]			
ANEMIA (HGB/HCT)[4]			
URINALYSIS (UA)[5]			
TB (Risk? Yes / No)[5]			
DEVELOPMENTAL ASSESSMENT[6]			
DATE OF LAST DENTIST'S EXAMINATION[7]			

Minimum requirements: [1] Up to 2 years; [2] annual at 3 years; [3] annual at 4 years; [4] 9 – 12 months, 2 years [5] as needed; [6] each visit through 5 yrs; [7] annual at 2 – 3 years
Prior to public school entry: Same as above and Hgb/hct

This child has the following conditions which may affect the educational experience:

☐ Vision ☐ Auditory ☐ Speech/Language ☐ Physical Dysfunction ☐ Emotional/Social ☐ Behavior

Re: Licensing: Does this child have a medical or emotional illness/disorder that now poses a risk to other children or affects the child's ability to participate safely in the program? ☐ yes ☐ no

☐ This child has a health condition which may require emergency action at school, e.g., seizures, allergies, asthma. *Specify below.*
☐ The child is on long-term or emergency medication. *Specify below.*

Comments and recommendations (attach additional sheet if necessary): _____

☐ This child may participate fully in the early childhood program.
☐ This child may participate in the early childhood program with the following restriction/adaptation: *(Specify reason and restriction)*

☐ Yes ☐ No Based on this comprehensive health history and physical examination, this child has maintained his/her level of wellness.
☐ I would like to discuss information in this report with the early childhood provider and/or health consultant/coordinator.

Signature of Health Care Provider	MD/DO NP PA	Name (please type or print)	Phone number
Address:			Next Appointment: (Mo/Yr): Next Appointment for Immunization (Mo/Yr):