



State of Connecticut and YMCA Health Assessment Record



To Parent or Guardian:

In order to provide the best educational experience, our personnel 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 medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant or the medical advisor prior to participation in school, child care or camp. An immunization update and additional health assessments are required in the sixth or seventh grade and in the tenth or eleventh grade for schools. Specific grade level will be determined by the local board of education.

Please print

Name of Child (Last, First, Middle)	Social Security Number	Birth Date	Sex
Address (Street)	Race/Ethnicity		
Town and Zip Code	<input type="checkbox"/> American Indian <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Other		
Home Telephone Number	School/ Program	Grade	
Name of Parent/Guardian (Last, First, Middle)			
Health Care Provider		Health Insurance Company/Number* or Medicaid/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. <input type="checkbox"/> | <input type="checkbox"/> | Do you have any concerns about your child's general health (overall eating and sleeping habits, teeth, etc.)? |
| 2. <input type="checkbox"/> | <input type="checkbox"/> | Has your child been diagnosed with any chronic disease <input type="checkbox"/> asthma <input type="checkbox"/> diabetes <input type="checkbox"/> seizure disorder <input type="checkbox"/> other: _____? |
| 3. <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any allergies (food, insects, medications, latex, etc.)? |
| 4. <input type="checkbox"/> | <input type="checkbox"/> | Does your child take any medications (daily or occasionally)? |
| 5. <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)? |
| 6. <input type="checkbox"/> | <input type="checkbox"/> | Has your child had any hospitalization, operation, major illness or injury, or significant accident? (Please specify). |
| 7. <input type="checkbox"/> | <input type="checkbox"/> | In the last 12 months, has your child experienced any difficulty with wheezing, excessive coughing or excessive night waking? (Please specify). |
| 8. <input type="checkbox"/> | <input type="checkbox"/> | In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination? (Please specify). |
| 9. <input type="checkbox"/> | <input type="checkbox"/> | Does your child have health insurance? (If your child does not have health insurance, call 1-877-CT-HUSKY). |
| 10. <input type="checkbox"/> | <input type="checkbox"/> | Does your child have dental insurance? |
| 11. <input type="checkbox"/> | <input type="checkbox"/> | Would you like to discuss anything about your child's health with the nurse? |

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 education needs in school, child care or camp.

Signature of Parent/Guardian

Date

PART II – MEDICAL EVALUATION

To the Health Care Provider: Please complete and sign.

Child's Name _____ Birth Date _____ has had a complete history and physical exam on _____ Month/Day/Year _____

FINDINGS FOR THIS CHILD ARE AS FOLLOWS:

Screening/Test Results <small>Note: *Mandated Screening/Text under Connecticut State Law</small>			Immunization Record																																																																																																														
*Height		BMI:	Vaccine (Month/Day/Year) <small>Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.</small> <table style="width: 100%; text-align: center; border-collapse: collapse;"> <tr> <td></td> <td>DOSE 1</td> <td>DOSE 2</td> <td>DOSE 3</td> <td>DOSE 4</td> <td>DOSE 5</td> <td>DOSE 6</td> </tr> <tr> <td>DTP</td> <td>*</td> <td>*</td> <td>*</td> <td>*</td> <td></td> <td></td> </tr> <tr> <td>DTP/Hib</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>DTaP</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>DT/Td</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>OPV</td> <td>*</td> <td>*</td> <td>*</td> <td></td> <td></td> <td></td> </tr> <tr> <td>IVP</td> <td>*</td> <td>*</td> <td>*</td> <td></td> <td></td> <td></td> </tr> <tr> <td>MMR</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Measles</td> <td>*</td> <td>*</td> <td></td> <td></td> <td colspan="2" style="text-align: right;"><small>Booster for entry into K and 7th grade</small></td> </tr> <tr> <td>Mumps</td> <td>*</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Rubella</td> <td>*</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>HIB</td> <td>*</td> <td></td> <td></td> <td></td> <td colspan="2" style="text-align: right;"><small>Child under age 5</small></td> </tr> <tr> <td>Hep B</td> <td>*</td> <td>*</td> <td>*</td> <td></td> <td colspan="2" style="text-align: right;"><small>Required for entry into K and 7th grade</small></td> </tr> <tr> <td>Varicella</td> <td>*</td> <td></td> <td></td> <td></td> <td colspan="2" style="text-align: right;"><small>Child born 1/1/97 or later Required for 7th grade entry</small></td> </tr> <tr> <td>PCV</td> <td></td> <td></td> <td></td> <td></td> <td colspan="2" style="text-align: right;"><small>Pneumococcal conjugate vaccine</small></td> </tr> </table>							DOSE 1	DOSE 2	DOSE 3	DOSE 4	DOSE 5	DOSE 6	DTP	*	*	*	*			DTP/Hib							DTaP							DT/Td							OPV	*	*	*				IVP	*	*	*				MMR							Measles	*	*			<small>Booster for entry into K and 7th grade</small>		Mumps	*						Rubella	*						HIB	*				<small>Child under age 5</small>		Hep B	*	*	*		<small>Required for entry into K and 7th grade</small>		Varicella	*				<small>Child born 1/1/97 or later Required for 7th grade entry</small>		PCV					<small>Pneumococcal conjugate vaccine</small>	
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*Weight:		*Postural:																																																																																																															
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Pulse:		<input type="checkbox"/> Abnormal																																																																																																															
*HCT/HGB:		Minimum _____																																																																																																															
Urinalysis:		Slight _____																																																																																																															
*Gross Dental:		Moderate _____																																																																																																															
Lead (Date/Result):		Marked _____																																																																																																															
		<input type="checkbox"/> Referral																																																																																																															
TB and Other Test Results (Sickle Cell, etc.)																																																																																																																	
TB: In high-risk group? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																																																	
TEST	DATE	RESULTS																																																																																																															
*Vision/Type of Screening			*Auditory/Type of Screening																																																																																																														
With glasses	R 20/ L 20/	Pass/Fail R																																																																																																															
Without glasses	R 20/ L 20/	L																																																																																																															
Chronic Disease Assessment:			Disease Hx																																																																																																														
YES NO			of above _____ <small>(Specify) (Date) (Confirmed by)</small>																																																																																																														
<input type="checkbox"/> <input type="checkbox"/>	Asthma:	<input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> exercise induced <input type="checkbox"/> unclassified																																																																																																															
<input type="checkbox"/> <input type="checkbox"/>	Diabetes:	<input type="checkbox"/> Type I <input type="checkbox"/> Type II																																																																																																															
<input type="checkbox"/> <input type="checkbox"/>	Anaphylactic reaction:	<input type="checkbox"/> food <input type="checkbox"/> insect <input type="checkbox"/> latex																																																																																																															
<input type="checkbox"/> <input type="checkbox"/>	Seizure Disorder:																																																																																																																
<input type="checkbox"/> <input type="checkbox"/>	Other: Please specify:																																																																																																																
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This child has the following problems which may adversely affect his or her school, child care or camp experience:

Vision Auditory Speech/Language Physical Dysfunction Emotional/Social Behavior

The child has a health condition which may require emergency action at school, child care or camp, e.g. seizures, allergies, anaphylaxis. *Specify below.*

The child is on long-term medication. *Specify below.*

Comments and recommendations (additional information about any of the above health assessment): _____

The child may participate fully in the school, child care and camp programs including physical education activities.

The child may participate in the school, child care and camp program and physical education 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 nurse or first aid provider.

Signature of Health Care Provider	Name/Group Practice <i>(Please type or print)</i>	Phone Number
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