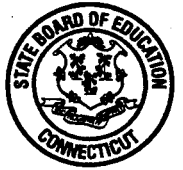




**State of Connecticut
Department of Education
Health Assessment Record**



To Parent or Guardian:

In order to provide the best educational experience, school 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 immunization and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant or the school medical advisor prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 10th or 11th grade. Specific grade level will be determined by the local board of education.

Please print

| | | | |
|---------------------------------------|----------------------------------|------------|-----|
| Name of Student (Last, First, Middle) | Social Security No. | Birth Date | Sex |
| Address (Street) | Home Telephone Number | | |
| (Town and Zip Code) | School | Grade | |
| Parent/Guardian (Last, First, Middle) | | | |
| Medicaid Number * | Health Insurance Company/Number* | | |

* If applicable

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 (eating and sleeping habits, weight, teeth, etc.)? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any other specific illness or problem? |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any allergies (food, insects, medication, etc.)? |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child take any medication (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, or major illness (specify problem)? |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | Has your child had any significant injury or accident (specify problem)? |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | Would you like to discuss anything about your child's health with the school 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 educational needs in school.

Signature of Parent/Guardian

Date

