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 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 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 Number	Birth Date	Sex

Address (Street) (Town and ZIP code)	Race/Ethnicity ❑ American Indian ❑ Asian ❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin ❑ Hispanic/Latino ❑ Other

Home Telephone Number	School	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.	❑	❑	Do you have any concerns about your child's general health (overall eating and sleeping habits, teeth, etc.)?
2.	❑	❑	Has your child been diagnosed with any chronic disease ❑ asthma ❑ diabetes ❑ seizure disorder ❑ other _____
3.	❑	❑	Does your child have any allergies (food, insects, medication, latex, etc.)?
4.	❑	❑	Does your child take any medications (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, major illness or injury, or significant accident? (Please specify.)
7.	❑	❑	In the last 12 months, has your child experienced any difficulty with wheezing, excessive coughing or excessive night waking? (Please specify.)
8.	❑	❑	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.	❑	❑	Does your child have health insurance? (If your child does not have health insurance, call 1-877-CT-HUSKY)
10.	❑	❑	Does your child have dental insurance?
11.	❑	❑	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

To be maintained in the student's Cumulative School Health Record