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, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base 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 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

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.

<table>
<thead>
<tr>
<th>Any health concerns</th>
<th>Y N</th>
<th>Hospitalization or Emergency Room visit</th>
<th>Y N</th>
<th>Concussion</th>
<th>Y N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies to food or bee stings</td>
<td>Y N</td>
<td>Any broken bones or dislocations</td>
<td>Y N</td>
<td>Fainting or blacking out</td>
<td>Y N</td>
</tr>
<tr>
<td>Allergies to medication</td>
<td>Y N</td>
<td>Any muscle or joint injuries</td>
<td>Y N</td>
<td>Chest pain</td>
<td>Y N</td>
</tr>
<tr>
<td>Any other allergies</td>
<td>Y N</td>
<td>Any neck or back injuries</td>
<td>Y N</td>
<td>Heart problems</td>
<td>Y N</td>
</tr>
<tr>
<td>Any daily medications</td>
<td>Y N</td>
<td>Problems running</td>
<td>Y N</td>
<td>High blood pressure</td>
<td>Y N</td>
</tr>
<tr>
<td>Any problems with vision</td>
<td>Y N</td>
<td>“Mono” (past 1 year)</td>
<td>Y N</td>
<td>Bleeding more than expected</td>
<td>Y N</td>
</tr>
<tr>
<td>Uses contacts or glasses</td>
<td>Y N</td>
<td>Has only 1 kidney or testicle</td>
<td>Y N</td>
<td>Problems breathing or coughing</td>
<td>Y N</td>
</tr>
<tr>
<td>Any problems hearing</td>
<td>Y N</td>
<td>Excessive weight gain/loss</td>
<td>Y N</td>
<td>Any smoking</td>
<td>Y N</td>
</tr>
<tr>
<td>Any problems with speech</td>
<td>Y N</td>
<td>Dental braces, caps, or bridges</td>
<td>Y N</td>
<td>Asthma treatment (past 3 years)</td>
<td>Y N</td>
</tr>
</tbody>
</table>

**Family History**

- Any relative ever have a sudden unexplained death (less than 50 years old) | Y N
- Any immediate family members have high cholesterol | Y N

Please explain all “yes” answers here. For illnesses/injuries/etc., include the year and/or your child’s age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any medications your child will need to take in school:

All medications taken in school require a separate Medication Authorization Form signed by a health care provider and parent/guardian.

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child’s health and educational needs in school.

Signed by Parent/Guardian

Date

To be maintained in the student’s Cumulative School Health Record
Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name ___________________________ Birth Date ___________ Date of Exam ___________

☐ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

*Height _____ in. / _____ %  *Weight _____ lbs. / _____ %  BMI _____ / _____ %  Pulse _____  *Blood Pressure _____ / _____

<table>
<thead>
<tr>
<th>Normal</th>
<th>Describe Abnormal</th>
<th>Ortho</th>
<th>Normal</th>
<th>Describe Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurologic</td>
<td></td>
<td></td>
<td>Neck</td>
<td></td>
</tr>
<tr>
<td>HEENT</td>
<td></td>
<td></td>
<td>Shoulders</td>
<td></td>
</tr>
<tr>
<td>*Gross Dental</td>
<td></td>
<td></td>
<td>Arms/Hands</td>
<td></td>
</tr>
<tr>
<td>Lymphatic</td>
<td></td>
<td></td>
<td>Hips</td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
<td>Knees</td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
<td>Feet/Ankles</td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitalia/ hernia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Screenings

*Vision Screening

Type:  Right  Left
With glasses  20/ 20/
Without glasses  20/ 20/
☐ Referral made

*Auditory Screening

Type:  Right  Left
☐ Pass  ☐ Pass
☐ Fail  ☐ Fail
☐ Referral made

History of Lead level ≥ 5µg/dL  ☐ No  ☐ Yes

*HCT/HGB:

*Speech (school entry only):

TB: High-risk group?  ☐ No  ☐ Yes  ☐ PPD date read:  Results:  Treatment:

*IMMUNIZATIONS

☐ Up to Date or  ☐ Catch-up Schedule: MUST HAVE IMMUNIZATION RECORD ATTACHED

*Chronic Disease Assessment:

Asthma  ☐ No  ☐ Yes:  ☐ Intermittent  ☐ Mild Persistent  ☐ Moderate Persistent  ☐ Severe Persistent  ☐ Exercise induced

If yes, please provide a copy of the Asthma Action Plan to School

Anaphylaxis  ☐ No  ☐ Yes:  ☐ Food  ☐ Insects  ☐ Latex  ☐ Unknown source

If yes, please provide a copy of the Emergency Allergy Plan to School

Allergies

History of Anaphylaxis  ☐ No  ☐ Yes  Epi Pen required  ☐ No  ☐ Yes

Diabetes  ☐ No  ☐ Yes:  ☐ Type I  ☐ Type II

Other Chronic Disease:

Seizures  ☐ No  ☐ Yes, type:

☐ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.

Explain: ____________________________________________________________

Daily Medications (specify): ________________________________________

This student may:  ☐ participate fully in the school program

☐ participate in the school program with the following restriction/adaptation: _____________________________________________

This student may:  ☐ participate fully in athletic activities and competitive sports

☐ participate in athletic activities and competitive sports with the following restriction/adaptation: _____________________________

☐ Yes  ☐ No  Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.

Is this the student’s medical home?  ☐ Yes  ☐ No  ☐ I would like to discuss information in this report with the school nurse.
# Immunization Record

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

**Vaccine (Month/Day/Year)** Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP</td>
<td>At least 4 doses, with the final dose on or after the 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.</td>
</tr>
<tr>
<td>Polio</td>
<td>At least 3 doses, with the final dose on or after the 4th birthday.</td>
</tr>
<tr>
<td>MMR</td>
<td>Required K-12th grade</td>
</tr>
<tr>
<td>Measles</td>
<td>Required K-12th grade</td>
</tr>
<tr>
<td>Mumps</td>
<td>Required K-12th grade</td>
</tr>
<tr>
<td>Rubella</td>
<td>Required K-12th grade</td>
</tr>
<tr>
<td>Hib</td>
<td>PK and K (Students under age 5)</td>
</tr>
<tr>
<td>Hep A</td>
<td>See below for specific grade requirement</td>
</tr>
<tr>
<td>Hep B</td>
<td>Required PK-12th grade</td>
</tr>
<tr>
<td>Varicella</td>
<td>Required K-12th grade</td>
</tr>
<tr>
<td>PCV</td>
<td>PK and K (Students under age 5)</td>
</tr>
<tr>
<td>Meningococcal</td>
<td>Required 7th-12th grade</td>
</tr>
<tr>
<td>HPV</td>
<td>Required K-12th grade</td>
</tr>
<tr>
<td>Flu</td>
<td>PK students 24-59 months old – given annually</td>
</tr>
</tbody>
</table>

**Disease Hx**

<table>
<thead>
<tr>
<th>of above</th>
<th>(Specify)</th>
<th>(Date)</th>
<th>(Confirmed by)</th>
</tr>
</thead>
</table>

**Exemption:** Religious: Permanent: Temporary: Date: ____________  

**Renew Date:** ____________

Religious exemption documentation is required upon school enrollment and then renewed at 7th grade entry.

Medical exemptions that are temporary in nature must be renewed annually.

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**Immunization Requirements for Newly Enrolled Students at Connecticut Schools (as of 8/1/17)**

### KINDERGARTEN THROUGH GRADE 6
- DTaP: At least 4 doses, with the final dose on or after the 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.  
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.  
- MMR: Required K-12th grade  
- Measles: Required K-12th grade  
- Mumps: Required K-12th grade  
- Rubella: Required K-12th grade  
- Hib: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).  
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).  
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday.  
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.  
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**

### GRADES 7 THROUGH 12
- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.  
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.  
- MMR: Required K-12th grade  
- Measles: Required K-12th grade  
- Mumps: Required K-12th grade  
- Rubella: Required K-12th grade  
- Hib: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.  
- Meningococcal: 1 dose  
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.  
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**  
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday.  
- Meningococcal: 1 dose  
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**

### HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES
- August 1, 2017: Pre-K through 5th grade  
- August 1, 2018: Pre-K through 6th grade  
- August 1, 2019: Pre-K through 7th grade  
- August 1, 2020: Pre-K through 8th grade  
- August 1, 2021: Pre-K through 9th grade  
- August 1, 2022: Pre-K through 10th grade  
- August 1, 2023: Pre-K through 11th grade  
- August 1, 2024: Pre-K through 12th grade

**Verification of disease:** Confirmation in writing by an MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

**Note:** The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nationwide shortage of supply for such vaccine.

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Initial/Signature of health care provider:  
Date Signed:  
Printed/Stamped **Provider** Name and Phone Number: