

State of Connecticut Department of Education Early Childhood Health Assessment Record



(For children ages birth -5)

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

			Please pr	int						
Child's Name (Last, First, Middle)					Birth Date (mm/dd/yyyy)			☐ Male ☐ Female		
Address (Street, Town and ZIP code)										
Parent/Guardian Name (Last, First, Middle)					Home Phone Cell Phone					
Early Childhood Program (Name and Phone Number)					Race/Ethnicity American Indian/Alaskan Native Hispanic/Latino					
Primary Health Care Provider:					☐ Black, not of Hispanic origin ☐ Asian/Pacific Islander ☐ White, not of Hispanic origin ☐ Other					
Name of Dentist:					Time, not of Inspanie origin					
Health Insurance Company/Num	ber*	or Me	edicaid/Number*							
Does your child have health insu Does your child have dental insu Does your child have HUSKY in	rance	?	Y N Y N Y N	r child d	loes n	ot hav	ve health insurance,	call 1-877-CT-HU	SKY	
* If applicable		_		_		_				
			I — To be completed			0				
Please answer these l	neal t	th hi	story questions abou	t your	chil	d be	fore the physic	al examination.	•	
Please circl	e Y i	f "yes	or ${f N}$ if "no." Explain all "	'yes" ans	swers	in the	e space provided be	low.		
Any health concerns	Y	N	Frequent ear infections		Y	N	Asthma treatment	Y	N	
Allergies to food, bee stings, insects	Y	N	Any speech issues		Y	N	Seizure	Y		
Allergies to medication	Y	N	Any problems with teeth		Y	N	Diabetes	Y		
Any other allergies	Y	N	Has your child had a dental				Any heart problem	s Y		
Any daily/ongoing medications	Y	N	examination in the last 6 mg	onths	Y	N	Emergency room v	visits Y	N	
Any problems with vision	Y	N	Very high or low activity le	vel	Y	N	Any major illness	or injury Y	N	
Uses contacts or glasses	Y	N	Weight concerns		Y	N	Any operations/sur	geries Y	N	
Any hearing concerns	Y	N	Problems breathing or coug	hing	Y	N	Lead concerns/pois	soning Y	N	
Developmental — Any concern about your child's:							Sleeping concerns Y			
Physical development	Y	N	5. Ability to communicate	needs	Y	N	High blood pressur	re Y	N	
2. Movement from one place			6. Interaction with others		Y	N	Eating concerns	Y		
to another	Y	N	7. Behavior		Y	N	Toileting concerns	Y	N	
3. Social development	Y	N	8. Ability to understand		Y	N	Birth to 3 services	Y	N	
4. Emotional development	Y	N	9. Ability to use their hands	S	Y	N	Preschool Special l	Education Y	N	
Explain all "yes" answers or provide	de any	y addi	tional information:							
Have you talked with your child's pri	imary	healt	h care provider about any of th	e above o	concer	ns?	Y N			
Please list any medications your chii will need to take during program hou										
All medications taken in child care progre	ıms rec	quire a	separate Medication Authorizatio	n Form si	igned b	y an au	athorized prescriber and	parent/guardian.		
I give my consent for my child's healt	h care	provi	der and early							
childhood provider or health/nurse consuthe information on this form for confichild's health and educational needs in the	dential	use i	n meeting my	arent/Gu	ardian	L			Date	