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 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.

Please print

Student Name (Last, First, Middle)	Birth Date	◯Male ◯Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity ◯ American Indian/ Alaskan Native ◯ Hispanic/Latino ◯ Black, not of Hispanic origin ◯ White, not of Hispanic origin ◯ Asian/Pacific Islander ◯ Other	
Primary Care Provider		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y◯ N◯
Does your child have dental insurance? Y◯ N◯

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

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.

Any health concerns	Y◯ N◯	Hospitalization or Emergency Room visit	Y◯ N◯	Concussion	Y◯ N◯
Allergies to food or bee stings	Y◯ N◯	Any broken bones or dislocations	Y◯ N◯	Fainting or blacking out	Y◯ N◯
Allergies to medication	Y◯ N◯	Any muscle or joint injuries	Y◯ N◯	Chest pain	Y◯ N◯
Any other allergies	Y◯ N◯	Any neck or back injuries	Y◯ N◯	Heart problems	Y◯ N◯
Any daily medications	Y◯ N◯	Problems running	Y◯ N◯	High blood pressure	Y◯ N◯
Any problems with vision	Y◯ N◯	"Mono" (past 1 year)	Y◯ N◯	Bleeding more than expected	Y◯ N◯
Uses contacts or glasses	Y◯ N◯	Has only 1 kidney or testicle	Y◯ N◯	Problems breathing or coughing	Y◯ N◯
Any problems hearing	Y◯ N◯	Excessive weight gain/loss	Y◯ N◯	Any smoking	Y◯ N◯
Any problems with speech	Y◯ N◯	Dental braces, caps, or bridges	Y◯ N◯	Asthma treatment (past 3 years)	Y◯ N◯
Family History				Seizure treatment (past 2 years)	Y◯ N◯
Any relative ever have a sudden unexplained death (less than 50 years old)			Y◯ N◯	Diabetes	Y◯ N◯
Any immediate family members have high cholesterol			Y◯ N◯	ADHD/ADD	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.

Signature of Parent/Guardian Date

SAMPLE FORM

YOUTH CAMP HEALTH EXAM/RECORD
FOR CAMPERS AND STAFF

☐ Camper
☐ Staff

Please Return Completed Form to the Camp

Name_____ Date of Birth_____ Phone_____

Guardian_____ Address_____

Emergency Contact_____ Telephone_____

Date of Arrival at Camp: _____ Departure Date: _____

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Date of Exam ____/____/____

May participate in all camp activities ☐ YES ☐ NO

May participate except for: _____

Does the individual have any known medical or emotional illness or disorder that poses a risk to other children or which affects the individual's functional ability to participate safely in a youth camp? ☐ YES ☐ NO

If yes, please explain _____

_____

Are there any prescription or over the counter medication(s) this individual needs to take while at camp? ☐ YES ☐ NO

If yes, indicate names of medication(s):_____

NOTE: A written authorization and parent permission for the administration of medication at camp are required.

Does the individual have any disabilities or special health care needs such as allergies, special dietary needs? ☐ YES ☐ NO

If yes, please explain _____

_____

NOTE: If the camper has a special health care need or disability that requires special care be taken or provided during the time the individual is at camp, an individual plan of care shall be developed with the parent and health care provider and updated as necessary. The plan shall include appropriate care of the camper in the event of a medical or other emergency and signed by the parent and staff responsible for the care of the camper.

If camper/staff is school aged or younger, have they been immunized in accordance with the schedule adopted by the Commissioner of Public Health pursuant to section 19a-7f of the Connecticut General Statutes? ☐ YES ☐ NO

Additional Comments:

_____

_____

Printed Name of Health Care Provider: _____

Address: _____ Phone: _____

Signature of Physician, PA, APRN or RN _____ Date Form Signed: _____