EWPS
East Windsor Public Schools
*Our graduates go places!*

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February 8, 2024

Dear Parent/Guardian,

The information below will assist you in completing the medical portion of your child's kindergarten registration. A completed state health assessment record, which is attached, is part of the required medical information for student registration. All four pages of the assessment require completion and

Page 1 – completed and signed by parent
Page 2 – completed by your pediatrician (every box completed including **lead level, TB risk, and hematocrit**)
Page 3 – completed by your dentist or pediatrician.
Page 4 - a copy of your child's immunizations must be attached to the completed health assessment form.

State law requires children to have a lead level completed between the ages of 1 and 2 years old. Lead level results must be written in the box on page 2 of the health assessment. If your child did not have one done, your pediatrician must order one and provide the school with the results. If you provided a lead level to our school nurse when your child had their preschool physical exam that box on the form does not need to be completed again.

Your child's physical exam and oral exam must be completed after July 1, 2023 as it must be done within twelve months of entry to school. **No child will be registered without all four pages of the health assessment record completed and proof of immunizations** on record at the school.

If your child requires a physical exam or immunizations and you are unable to obtain an appointment with your pediatrician before school starts or you are new to the area, please contact our School Based Health Center at the Broad Brook Elementary School 860-623-2433 ext. 5155 or 5172. They can schedule an appointment for your child with our Nurse Practitioner.

The state health assessment record is also located on our school website under the health tab. **Please bring the form to your child's physician at the time of your child's physical exam.** If you have any questions please contact the school nurse, Kathryn Smyrak at 860- 627-4986 or email the nurse @ bbsnurse@ewct.org. Forms can be faxed to the school nurse at 860-386-6059.

Sincerely,
Wendy Gage RN BSN NCSN
Wendy Gage RN BSN NCSN
Health Care Coordinator

* Completed by parent *

# 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 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

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.

*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<br>❑ American Indian/ Alaskan Native<br>❑ Hispanic/Latino | ❑ Black, not of Hispanic origin<br>❑ White, not of Hispanic origin<br>❑ Asian/Pacific Islander<br>❑ Other |
| Primary Care Provider | | |
| Health Insurance Company/Number* or Medicaid/Number* | | |
| Does your child have health insurance? Y N<br>Does your child have dental insurance? Y N | If your child does not have health insurance, call **1-877-CT-HUSKY** | |

* If applicable

## Part 1 — 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.

X _____ Signature of Parent/Guardian Date

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

*Completed by pediatrician*

# Part 2 — Medical Evaluation

HAR-3 REV. 1/2022

**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 1 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**_____/ _____

| | Normal | Describe Abnormal | Ortho | Normal | Describe Abnormal |
|---|---|---|---|---|---|
| Neurologic | | | Neck | | |
| HEENT | | | Shoulders | | |
| *Gross Dental | | | Arms/Hands | | |
| Lymphatic | | | Hips | | |
| Heart | | | Knees | | |
| Lungs | | | Feet/Ankles | | |
| Abdomen | | | | | |
| Genitalia/ hernia | | | | | |
| Skin | | | | | |

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

## 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

| | Date |
|---|---|
| History of Lead level ≥ 5µg/dL ❑ No ❑ Yes | |
| ***HCT/HGB:** | |
| ***Speech** (school entry only) | |
| Other: | |

**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

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

Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

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# Part 3 — Oral Health Assessment/Screening

## Health Care Provider must complete and sign the oral health assessment.

*Completed by dentist or pediatrician*

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

| Student Name (Last, First, Middle) | Birth Date | Date of Exam |
|---|---|---|
| School | Grade | ❑ Male ❑ Female |
| Home Address | | |
| Parent/Guardian Name (Last, First, Middle) | Home Phone | Cell Phone |

| **Dental Examination** | **Visual Screening** | **Normal** | **Referral Made:** |
|---|---|---|---|
| Completed by:<br>❑ Dentist | Completed by:<br>❑ MD/DO<br>❑ APRN<br>❑ PA<br>❑ Dental Hygienist | ❑ Yes<br>❑ Abnormal (Describe)<br>_____<br>_____<br>_____<br>_____<br>_____ | ❑ Yes<br>❑ No |

| **Risk Assessment** | **Describe Risk Factors** | |
|---|---|---|
| ❑ Low<br>❑ Moderate<br>❑ High | ❑ Dental or orthodontic appliance<br>❑ Saliva<br>❑ Gingival condition<br>❑ Visible plaque<br>❑ Tooth demineralization<br>❑ Other _____ | ❑ Carious lesions<br>❑ Restorations<br>❑ Pain<br>❑ Swelling<br>❑ Trauma<br>❑ Other _____ |

Recommendation(s) by health care provider: _____

_____

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

_____

Signature of health care provider — DMD / DDS / MD / DO / APRN / PA/ RDH — Date Signed — Printed/Stamped ***Provider*** Name and Phone Number

**Student Name:** _____ **Birth Date:** _____ HAR-3 REV. 1/2022

# 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.

| | Dose 1 | Dose 2 | Dose 3 | Dose 4 | Dose 5 | Dose 6 |
|---|---|---|---|---|---|---|
| **DTP/DTaP** | * | * | * | * | | |
| **DT/Td** | | | | | | |
| **Tdap** | * | | | | Required 7th-12th grade | |
| **IPV/OPV** | * | * | * | | | |
| **MMR** | * | * | | | Required K-12th grade | |
| **Measles** | * | * | | | Required K-12th grade | |
| **Mumps** | * | * | | | Required K-12th grade | |
| **Rubella** | * | * | | | Required K-12th grade | |
| **HIB** | * | | | | PK and K (Students under age 5) | |
| **Hep A** | * | * | | | See below for specific grade requirement | |
| **Hep B** | * | * | * | | Required PK-12th grade | |
| **Varicella** | * | * | | | Required K-12th grade | |
| **PCV** | * | | | | PK and K (Students under age 5) | |
| **Meningococcal** | * | | | | Required 7th-12th grade | |
| **HPV** | | | | | | |
| **Flu** | * | | | | PK students 24-59 months old – given annually | |
| **Other** | | | | | | |

**Disease Hx of above** _____ (Specify) _____ (Date) _____ (Confirmed by)

**Religious Exemption:** _____

**Religious exemptions must meet the criteria established in Public Act 21-6: https://portal.ct.gov/-/media/SDE/Digest/2020-21/CSDE-Guidance---Immunizations.pdf.**

**Medical Exemption:** _____

**Must have signed and completed medical exemption form attached. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf**

### 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: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the1st 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. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.
- 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 the1st 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: 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. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.

### 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.

Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number