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

**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.)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Do you have any concerns about your child’s general health, development or behavior?</td>
</tr>
<tr>
<td>2.</td>
<td>Has your child been diagnosed with any chronic disease asthma diabetes seizure disorder other</td>
</tr>
<tr>
<td>3.</td>
<td>Does your child have any allergies (food, insects, medication, latex, etc.)? Please specify:</td>
</tr>
<tr>
<td>4.</td>
<td>Does your child take any medications (daily or occasionally)?</td>
</tr>
<tr>
<td>5.</td>
<td>Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)?</td>
</tr>
<tr>
<td>6.</td>
<td>Has your child had any hospitalization, operation, major illness or injury, or significant accident?</td>
</tr>
<tr>
<td>7.</td>
<td>In the last 12 months, has your child experienced any difficulty with wheezing or excessive night coughing?</td>
</tr>
<tr>
<td>8.</td>
<td>In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination?</td>
</tr>
<tr>
<td>9.</td>
<td>Has your child had a dental examination in the last 12 months?</td>
</tr>
<tr>
<td>10.</td>
<td>Would you like to discuss anything about your child’s health with the child care provider or health consultant/coordinator?</td>
</tr>
</tbody>
</table>

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

__________________________
Signature of Parent/Guardian

__________________________
Date

I give permission for release of information on this form for confidential use in meeting my child’s health and educational needs in the early childhood program.
**Part II — Health Evaluation**

To the Health Care Provider: Please complete all sections and sign. Explain any screenings required by age but not conducted.

<table>
<thead>
<tr>
<th>LENGTH/HEIGHT</th>
<th>WEIGHT</th>
<th>WT FOR HT/BMI</th>
<th>HEAD CIRCUMFERENCE</th>
<th>BLOOD PRESSURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>IN/CM %ILE</td>
<td>LB/KG %ILE</td>
<td>%ILE</td>
<td>IN/CM %ILE</td>
<td></td>
</tr>
</tbody>
</table>

**Screening/Test Results**

<table>
<thead>
<tr>
<th>Screening/Test</th>
<th>Result</th>
<th>Date</th>
<th>Abnormal/Comments</th>
</tr>
</thead>
</table>

**Immunization Record**

<table>
<thead>
<tr>
<th>Vaccine (Month/Day/Year)</th>
<th>Dose 1</th>
<th>Dose 2</th>
<th>Dose 3</th>
<th>Dose 4</th>
<th>Dose 5</th>
<th>Dose 6</th>
</tr>
</thead>
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<th>Dose 4</th>
<th>Dose 5</th>
<th>Dose 6</th>
</tr>
</thead>
</table>

**Other Vaccines (Specify)**

**Exemption**

- Religious ______
- Medical: Permanent ______
- Temporary ______
- Date ______

**Recertify Date ________**

**Minimum requirements:** 1Up to 2 years; 2annual at 3 years; 3annual at 4 years; 4as needed; 59–12 months; 6each visit through 5 years; 7annual at 2–3 years. Federal requirements (eg, Head Start, WIC) may vary.

*Prior to Public School Entry: Same as above and Hgb/hct.

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**Chronic Disease Assessment:**

- **Yes**
- **No**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Date of onset</th>
</tr>
</thead>
</table>

- **Asthma:** mild moderate severe
- **exercise induced** unclassified
- **Diabetes:** Type I Type II
- **Anaphylaxis:** med. food insect latex
- **Seizures:** Type
- **Other:** Please specify

**Has this child received dental care in the last 12 months?**

- **Yes**
- **No**
- N/A

**Developmental Assessment**

**Has this child received dental care in the last 12 months?**

**Vision**

**Hearing**

**Lead**

**TB**

**Urinalysis (UA)**

**Anemia**

**Developmental Assessment**

**Has this child received dental care in the last 12 months?**

- **Yes**
- **No**
- N/A

**Other:** Please specify

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**This child has the following problems which may adversely affect his or her educational experience:**

- **Yes**
- **No**

**The child has a health condition which may require intervention at the program, e.g., seizures, allergies, asthma, anaphylaxis, special diet, long-term medication. Specify:**

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**I would like to discuss information in this report with the early childhood provider and/or health consultant/coordinator.**

**Signature of health care provider**

**MD/DO NP PA**

**Name (Please type or print.)**

**Phone number**

**Address:**

- **Yes**
- **No**

**Is this the child’s Medical Home?**

**Next Appointment (mm/yy):**

**Next Immunization Appointment (mm/yy):**