



Departamento de Educación del estado de Connecticut
Registro de la evaluación de salud de la niñez temprana



Al Padre, la madre o el tutor:

Para poder brindarle el mejor servicio, los proveedores de atención médica de la niñez temprana deben entender las necesidades de salud de su hijo. En la primera parte de este formulario le pedimos información sobre la salud de su hijo. Ésta ayudará a los médicos para su evaluación (Parte II). Antes de poder ingresar a un Programa de la Niñez Temprana, la ley del estado requiere que un médico, enfermera de práctica avanzada, asociado médico, profesional de la salud certificado legalmente o un asociado médico

asignado a una base militar realice una evaluación de salud y le haya puesto las vacunas principales Connecticut (C.G.S. Secs. 10-204a and 10-206). Una revisión de inmunización y evaluaciones de salud adicionales son necesarias en el 6° o 7° grado y en el noveno o décimo grado. El grado específico será determinado por la junta local de educación. Este formulario también puede ser utilizado para las evaluaciones de salud necesarias cada año para los estudiantes que vayan a participar en los equipos deportivos.

Por favor escriba en letra de imprenta

Nombre del Estudiante (apellido, nombre, segundo nombre)		Fecha de Nacimiento	<input type="checkbox"/> Niño <input type="checkbox"/> Niña
Dirección (calle, poblado y código postal)			
Nombre del padre, la madre o tutor (apellido, nombre, 2do nombre)		Teléfono de la casa	Teléfono celular
Escuela/ Grado		Raza/ Procedencia étnico <input type="checkbox"/> Negro, no de origen hispano <input type="checkbox"/> Nativo americano / <input type="checkbox"/> Blanco no de origen hispano <input type="checkbox"/> de Alaska <input type="checkbox"/> Asiático/ Islas del Pacífico	
Médico de cabecera		<input type="checkbox"/> Hispano/Latino <input type="checkbox"/> Otro	
Compañía de seguro médico/Número* o Medicaid/Número*			
¿Su hijo tiene seguro médico?	S N	Si su hijo no tiene seguro medico, llame al-1-877-CT-HUSKY	
¿Su hijo tiene seguro dental?	S N		

* Si aplica

Parte I — El padre, la madre o el tutor legal debe llenar esta parte.

Antes del examen físico, por favor conteste las siguientes preguntas acerca de la salud de su hijo(a).

Encierre en un círculo la S si la respuesta es "sí" o la N si la respuesta es "no".

En el espacio que aparece a continuación, ofrezca una explicación a todas las preguntas a las que contestó "sí".

Alguna inquietud sobre la salud	S N	Hospitalización o Visitas a la sala de emergencias	S N	Contusión cerebral	S N
Alergia de comida, picaduras de insectos	S N	Hueso roto o dislocado	S N	Se ha desmayado	S N
Alergia a algún medicamento	S N	Herida de musculo o coyuntura	S N	Dolor en el pecho	S N
Alguna otra alergia	S N	Herida al cuello o la espalda	S N	Algún problema del corazón	S N
Toma medicamentos diariamente	S N	Problema cuando corre	S N	Presión sanguínea alta	S N
Alguna dificultad con la visión	S N	"Mono" (en el último año)	S N	Sangrando más de lo normal	S N
Usa lentes de contacto o anteojos	S N	Tiene un riñón o testículo	S N	Dificultad con la respiración o tiene tos	S N
Alguna dificultad con la audición	S N	Aumentó o bajó de peso en exceso	S N	Ha fumado	S N
Alguna dificultad del habla	S N	Frenillos, capas o puentes dentales	S N	Tratamientos para el asma (últimos 3 años)	S N
Historial Familiar				Tratamiento de convulsiones (últimos 2 años)	S N
Algún pariente ha tenido una repentina muerte inexplicable (menos de 50 años)		S N	Diabetes	S N	
Algún miembro de la familia inmediata tiene el colesterol alto		S N	ADHD/ADD	S N	

Si respondió "SI" a alguna de las preguntas, explique su respuesta o proporcione información adicional. Para las heridas o enfermedades favor de incluir el año y la edad del niño cuando pasó:

¿Hay algo que quieres discutir con la enfermera escolar? S N Si la respuesta es "Si", explique:

Por favor apunte el nombre de cualquier medicamento que su hijo tendrá que tomar mientras asiste al programa:

En caso de que sea necesario administrar algún medicamento durante el Programa, el medico que le recetó el medicamento y el padre, la madre o el tutor legal deben firmar una autorización adicional llamada Medication Authorization Form (formulario de autorización para administrar medicamentos).

Por este medio doy autorización al médico de mi hijo y al profesional de la niñez temprana o al asesor/enfermera/coordinador de salud a que compartan, confidencialmente, la información de este formulario, para cubrir las necesidades educativas y de salud de mi hijo(a) en el programa de la niñez temprana.

Firma del padre, la madre o del tutor

Fecha

Part 2 — Medical Evaluation

HAR-3 REV. 7/2018

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			*Postural <input type="checkbox"/> No spinal abnormality <input type="checkbox"/> Spine abnormality: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Referral made		
Genitalia/ hernia					
Skin					

Screenings

*Vision Screening			*Auditory Screening			History of Lead level	Date
Type:	Right	Left	Type:	Right	Left	≥ 5µg/dL <input type="checkbox"/> No <input type="checkbox"/> Yes	
With glasses	20/	20/	<input type="checkbox"/> Pass	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	*HCT/HGB:	
Without glasses	20/	20/	<input type="checkbox"/> Fail	<input type="checkbox"/> Fail	<input type="checkbox"/> Fail	*Speech (school entry only)	
<input type="checkbox"/> Referral made			<input type="checkbox"/> Referral made			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
---	-------------	--

Part 3 — Oral Health Assessment/Screening

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

HAR-3 REV. 7/2018

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	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination Completed by: <input type="checkbox"/> Dentist	Visual Screening Completed by: <input type="checkbox"/> MD/DO <input type="checkbox"/> APRN <input type="checkbox"/> PA <input type="checkbox"/> Dental Hygienist	Normal <input type="checkbox"/> Yes <input type="checkbox"/> Abnormal (Describe) _____ _____ _____ _____	Referral Made: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Risk Assessment <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	Describe Risk Factors <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none; vertical-align: top;"> <input type="checkbox"/> Dental or orthodontic appliance <input type="checkbox"/> Saliva <input type="checkbox"/> Gingival condition <input type="checkbox"/> Visible plaque <input type="checkbox"/> Tooth demineralization <input type="checkbox"/> Other _____ </td> <td style="width: 33%; border: none; vertical-align: top;"> <input type="checkbox"/> Carious lesions <input type="checkbox"/> Restorations <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____ </td> <td style="width: 34%; border: none;"></td> </tr> </table>			<input type="checkbox"/> Dental or orthodontic appliance <input type="checkbox"/> Saliva <input type="checkbox"/> Gingival condition <input type="checkbox"/> Visible plaque <input type="checkbox"/> Tooth demineralization <input type="checkbox"/> Other _____	<input type="checkbox"/> Carious lesions <input type="checkbox"/> Restorations <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____	
<input type="checkbox"/> Dental or orthodontic appliance <input type="checkbox"/> Saliva <input type="checkbox"/> Gingival condition <input type="checkbox"/> Visible plaque <input type="checkbox"/> Tooth demineralization <input type="checkbox"/> Other _____	<input type="checkbox"/> Carious lesions <input type="checkbox"/> Restorations <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Trauma <input type="checkbox"/> 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
-----------------------------------	---------------------------------------	-------------	--

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) _____

Exemption: Religious _____ Medical: 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.

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: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- 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. 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 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: 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
---	-------------	--