BrightPath Kids Early Childhood Health Assessment Record

To Parent or Guardian: In order to provide the best experience, early childhood education providers must understand your child's health needs. This form requests information from you (Part I) and information from your child's health care provider (Part II). Connecticut state law requires complete primary immunizations and a health assessment by a physician, an advance practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine prior to entering an early childhood education program in CT.

Part I – To be completed by child's parent/guardian

Please Print

____ ____________________ ☐ Male ☐ Female

Child's Name (First, Last) Birth Date

____

Address (Street, Town, State, and Zip)

____ __________________ __________________

Parent/Guardian Name (First, Last) Home Phone Mobile Phone

____________________________________ ____________________________________

Child's Primary Health Care Provider Child's Dentist

____________________________________ ____________________________________

Health Insurance Company ID Number or Medicaid Number

I give consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information in these forms for confidential use in meeting my child's health and educational needs in the early childhood education program.

____ ________________________

Parent/Guardian Signature Date

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name ______________________________ Birth Date ____________ (mm/dd/yyyy) Date of Exam ____________ (mm/dd/yyyy)

❑ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

***HT** ____ in/cm ____% ***Weight** ____ lbs. ____ oz / ____% **BMI** ____ / ____% ***HC** ____ in/cm ____% (Birth – 24 months) ***Blood Pressure** ____ / ____ (Annually at 3 – 5 years)

Screenings

*Vision Screening	*Hearing Screening	*Anemia: at 9 to 12 months and 2 years
❑ EPSDT Subjective Screen Completed (Birth to 3 yrs) ❑ EPSDT Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment) Type: Right / Left With glasses 20/ 20/ Without glasses 20/ 20/ ❑ Unable to assess ❑ Referral made to: ________	❑ EPSDT Subjective Screen Completed (Birth to 4 yrs) ❑ EPSDT Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment) Type: Right / Left ❑ Pass ❑ Pass ❑ Fail ❑ Fail ❑ Unable to assess ❑ Referral made to: ________	*Hgb/Hct: *Date *Lead: at 1 and 2 years; if no result screen between 25 – 72 months Lead poisoning (≥ 10ug/dL) ❑ No ❑ Yes *Result/Level: *Date
*TB: High-risk group? ❑ No ❑ Yes Test done: ❑ No ❑ Yes Date: _______ Results: ________ Treatment: ________	*Dental Concerns ❑ No ❑ Yes ❑ Referral made to: ________ Has this child received dental care in the last 6 months? ❑ No ❑ Yes	Other:

***Developmental Assessment:** (Birth – 5 years) ❑ No ❑ Yes **Type:**

Results:

*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 an **Asthma Action Plan***
❑ Rescue medication required in child care setting: ❑ No ❑ Yes

Allergies ❑ No ❑ Yes: ____________________
Epi Pen required: ❑ No ❑ Yes
History/risk of Anaphylaxis: ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Medication ❑ Unknown source
*If yes, please provide a copy of the **Emergency Allergy Plan***

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:** ____________________

Seizures ❑ No ❑ Yes: Type: ____________ ____________________

❑ This child has the following problems which may adversely affect his or her educational experience:
❑ Vision ❑ Auditory ❑ Speech/Language ❑ Physical ❑ Emotional/Social ❑ Behavior

❑ This child has a developmental delay/disability that may require intervention at the program.

❑ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:*____________________

❑ No ❑ Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.

❑ No ❑ Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.

❑ No ❑ Yes This child may fully participate in the program.

❑ No ❑ Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)
____

❑ No ❑ Yes Is this the child's medical home? ❑ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

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

Child's Name: ____________________ Birth Date: ____________________ REV. 8/2011

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) ____________________

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Flu						
Other						

Disease history for varicella (chickenpox) ____________________
(Date) (Confirmed by)

Exemption: **Religious** _____ **Medical: Permanent** _____ **†Temporary** _____ **Date** _____

†Recertify Date _________ †Recertify Date _________ †Recertify Date ________

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2-3 years of age (24-35 mos.)	3-5 years of age (36-59 mos.)
DTP/DTaP/ DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

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