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) Poole Hayley A	Birth Date 3/29/96	☐ Male ☒ Female
Address (Street, Town and ZIP code) #102 Avalon Valley Dr		
Parent/Guardian Name (Last, First, Middle) Mourtzinis, Linda	Home Phone 203 3005812	Cell Phone 860 975 7348
School/Grade Danbury H.S. /	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*
HNT 8203277501

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.

Depression & ADHD

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 healthcare 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

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

Part II — Medical Evaluation

HAR-3 REV. 4/2011

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name Maylon Poole Birth Date 3/09/96 Date of Exam 10/13/12

☐ 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 under Connecticut State Law

***Height** 69 in. / ____ % ***Weight** 162 lbs. / 95 % **BMI** 24.85 % **Pulse** 88 ***Blood Pressure** 120 / 88

	Normal	Describe Abnormal
Neurologic	✓	
HEENT	✓	
*Gross Dental	✓	
Lymphatic	✓	
Heart	✓	
Lungs	✓	
Abdomen	✓	
Genitalia/ hernia	✓	
Skin	✓	

Ortho	Normal	Describe Abnormal
Neck	✓	
Shoulders	✓	
Arms/Hands	✓	
Hips	✓	
Knees	✓	
Feet/Ankles	✓	

***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
Lead:	
***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: ADHD, Depression
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
[signature]	10/13/12	

Student Name: _____ Birth Date: _____ HAR-3 REV. 4/2011

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 for 7th grade entry	
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	*	*			PK and K (born 1/1/2007 or later)	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			2 doses required for K & 7th grade as of 8/1/2011	
PCV	*				PK and K (born 1/1/2007 or later)	
Meningococcal	*				Required for 7th grade entry	
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** _____

Recertify Date _____ Recertify Date _____ Recertify Date _____

Immunization Requirements for Newly Enrolled Students at Connecticut Schools

KINDERGARTEN

- DTaP: At least 4 doses. The last dose must be given on or after 4th birthday.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 day apart – 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after 1st birthday (Children 5 years and older do not need proof of Hib vaccination).
- Pneumococcal: 1 dose on or after 1st birthday (born 1/1/2007 or later and less than 5 years old).
- Hep A: 2 doses given six months apart-1st dose on or after 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: For students enrolled before August 1, 2011, 1 dose given on or after 1st birthday; for students enrolled on or after August 1, 2011 2 doses given 3 months apart – 1st dose on or after 1st birthday or verification of disease*.

GRADES 1-6

- DTaP /Td/Tdap: At least 4 doses. The last dose must be given on or after 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. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart-1st dose on or after the 1st birthday.
- Hep B: 3 doses – the last dose on or after 24 weeks of age.
- Varicella: 1 dose on or after the 1st birthday or verification of disease*.

GRADE 7

- Tdap/Td: 1 dose of Tdap for students 11 yrs. or older enrolled in 7th grade who completed their primary DTaP series; For those students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are needed, one of which **must** be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart – 1st dose on or after the 1st birthday.
- Meningococcal: one dose for students enrolled in 7th grade.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: 2 doses given 3 months apart – 1st dose on or after 1st birthday or verification of disease*.

GRADES 8-12

- Td: At least 3 doses. Students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine one of which should be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart-1st dose on or after the 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: For students <13 years of age, 1 dose given on or after the 1st birthday. For students 13 years of age or older, 2 doses given at least 4 weeks apart or verification of disease*.

* **Verification of disease:** Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

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

Vaccine Administration Record

Overwell ? Dr 8/25/?? 311

Patient Name Poole, Marylou

Birthdate 3-29-96

Record # 5231.1

PUTNAM PEDIATRIC ASSOCIATES, P.C.
RD 9 DREWVILLE RD
CARMEL, N.Y. 10512

Tel. (914) 279-9652
279-5131

"I have been provided a copy, and have read or have had explained to me, information about the diseases and the vaccines listed below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines cited and ask that the vaccine(s) listed below be given to me or to the person named above (for whom I am authorized to make this request)."

Vaccine	Date Given m/d/y	Age	*Site	Vaccine Manufacturer	Vaccine Lot Number	**Handout Publ. Date	***Initials	Signature of Parent or Guardian
~~DTP 1~~ DT Ped	6/7/96							
~~DTP 2~~ DT Ped	8/6/96	4 mos	LT	Conn 11/21/96	4L61162	8/6/96	DS	[signature]
~~DTP 3~~ DT Ped	10/10/96	6 mos	left thigh	Connaught	5F71080 6/97		[initials]	[signature]
~~DTP/DTaP4~~ DT Ped	10-29-97	19 mos	LA	Conn 9/98	6K81446		AB	[signature]
DTP/DTaP5 ✓								
DT Ped	6/11/01	5 yrs	left arm	Connaught	4B306AB 7/03	5/15/97	[initials]	[signature]
DTP/Hib1 IPV	6/11/01	5 yrs	rt arm only	Connaught	T1842 3/03	1/1/01	[initials]	[signature]
DTP/Hib2								
DTP/Hib3								
DTP/Hib 4								
Td Boostrix	7/10/07	11 yr	LD	GSK 3/30/09	AC52B018BA	9/22/05	[initials]	[signature]
OPV/IPV 1	~~6/7/96~~	~~4 mos~~	~~RT~~					
OPV/IPV 2	6/7/96	4 mos	RT	Conn 8/30/98	L1114	8/6/96	DS	[signature]
OPV/IPV 3	10/10/96	6 mos	left thigh	Connaught	L1194	11/98	[initials]	[signature]
OPV/IPV 4	10-29-97	19 mos	PO	Led 1/98	0765B		AB	[signature]
MMR 1	6/23/97	15 1/2 mos	left arm only	MSD	0283E 2/99		[initials]	[signature]
MMR 2	4/11/00	4 yrs	left arm only	MSD	1714J 1/01		[initials]	X
Hib 1	6/7/96							
Hib 2	10/10/96	6 mos	rt thigh	Praxis	M005LP 4/96		[initials]	[signature]
Hib 3	12/17/96	8 mos	LT	Fedy 11/97	1234 D		LS	[signature]
Hib 4 ActHib	10-29-97	19 mos	RA	Conn 4/99	7D91905		AB	[signature]
Hep B 1	4/25/96							
Hep B 2	7/15/96	3 1/2 mos	left thigh	SK Beecham	Eng206182 2/98		[initials]	[signature]
Hep B 3	1/8/97	9 mos	RT	SKB 7/99	ENG 2151A2		AB	[signature]
Varivax	3/23/99	3 yrs	LT	Merck 5/00	1850H		LS	[signature]

*** Initials	Signature of Vaccine Administrator
[initials]	Y. [signature] LPN
DS	Dorothea Schuldeis LPN
LS	[signature]
AB	AB Brandt [signature]
	[signature] RN

(Use reverse side if more signatures are needed)

*Site Given Legend

RA = Right Arm
LA = Left Arm
RT = Right Thigh
LT = Left Thigh
O = Oral

** If required by state law

American Academy of Pediatrics

CONFIDENTIAL

Form 149360 Colwell Systems, Champaign, IL

5231.1

...had explained, the information about the diseases and the vaccines listed below. There was an opportunity to ask questions and any questions were answered satisfactorily. I/We believe that I/we understand the benefits and risks of the vaccine cited, and ask that the vaccine(s) listed below be given to me/us or to the person named above (for whom I/we are authorized to make this request).

Vaccine (eg, Hep A, Influenza, Lyme, Meningococcal, 23-Valent Pneumococcal Polysaccharide)

VACCINE (Fill in)	VACCINE ADMINISTERED			FUNDING SOURCE (F, S, P)†	VACCINE			VACCINE INFORMATION STATEMENTS		Vaccine Administrator Initials ‡
	Date m/d/y	Patient Age	Site on Patient*		Manufacturer	Lot Number	Expiration Date	Date Published	Date Provided	
Menactra	10/14/09	13yr	LA		Sanofi	U3096AA	2/18/11	1/28/08	10/14/09	[illegible]
Gardasil-1	6/10/11	15yr	[illegible]		Merck	0636AA	8/13		6/10/11	MM
Gardasil-2	4/5/12	—	Prev	MD						
Gardasil 3	10/13/12	16yr	LA		Merck	H012973	3/5/15	2/22/12	10/13/12	JG

† F = Federal, S = State, P = Private

*Site Given Legend	‡ Full Signature of Vaccine Administrator or Parent/Guardian(s)
O = Oral	[illegible] E Callahan RN
LT = Left Thigh	MM [illegible]
RT = Right Thigh	JG [illegible] LPN
LA = Left Arm	
RA = Right Arm	

PUTNAM PEDIATRIC ASSOCIATES, P.C.

THE BARNS OFFICE CENTER, 667 STONELEIGH AVE., SUITE 116, CARMEL, NEW YORK 10512

FORM 018650 N/01/01 ITEM 6370 COLWELL SYSTEMS 1.8