Bright Morning Star Daycare, LLC

Early Childhood Health Assessment Record

(For children ages birth – 5)

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

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	□ Male □ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone Cell Phone	
Early Childhood Program (Name and Phone Number)	Race/Ethnicity □ American Indian/Alaskan Native □ Hispanic/Latino □ Black, not of Hispanic origin □ White, not of Hispanic origin □ Asian/Pacific Islander ☒ Other	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		
Does your child have health insurance? Y N Does your child have dental insurance? Y N Does your child have HUSKY insurance? Y N		

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	Frequent ear infections	Y N	Asthma treatment	Y N
Allergies to food, bee stings, insects?	Y N	Any speech issues	Y N	Seizure	Y N
Allergies to medication	Y N	Any problems with teeth	Y N	Diabetes	Y N
Any other allergies	Y N	Has your child had a dental examination in the last 6 months	Y N	Any heart problems	Y N
Any daily/ongoing medications	Y N			Emergency room visits	Y N
Any problems with vision	Y N	Very high or low activity level	Y N	Any major illness or injury	Y N
Uses contacts or glasses	Y N	Weight concerns	Y N	Any operations/surgeries	Y N
Any hearing concerns	Y N	Problems breathing or coughing	Y N	Lead concerns/poisoning	Y N
Developmental — Any concern about your child's:				Sleeping concerns	Y N
1. Physical development	Y N	5.Ability to communicate needs	Y N	High blood pressure	Y N
2.Movement from one place to another	Y N	6.Interaction with others	Y N	Eating concerns	Y N
		7.Behavior	Y N	Toileting concerns	Y N
3.Social development	Y N	8.Ability to understand	Y N	Birth to 3 services	Y N
4.Emotional development	Y N	8.Ability to use their hands	Y N	Preschool Special Education	Y N
Explain all "yes" answers or provide any additional information:					

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:_____

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

Signature of Parent/Guardian_____ 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_____Date of Exam_____
(mm/dd/yyyy) (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** □ 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: _____	***Hearing Screening** □ 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: _____	***Anemia:** at 9 to 12 months and 2 years ***Hgb/Hct:** *Date ***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months Lead poisoning (≥ 10ug/dL) □No □Yes
***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	*Result/Level: *Date **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: _____

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 _____**
†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	By 16-18 months of age	By 19 months of age	By 2-3years of age	3-5years of age
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 dose	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

_____

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

Bright Morning Star Daycare, LLC

EMERGENCY MEDICAL CARE

Attention Provider: *Carry a copy of this form and the Child Health Record during any off-premises child care activity. Please verify with the emergency medical care facility to assure that this form is acceptable.*

Child's name:_____Parent'sname:_____

Parent's name:_____

Address:_____ Town: _____Zip Code:_____

Allergies:_____ Last Tetanus_____

Medical Facility:_____ Phone #:_____

Insurance Carrier and_____InsuranceID:_____

Physician to be called in an emergency:

Name:_____ Phone #:_____

Address:_____ Town_____ Zip Code:_____

I give my consent for the day care provider named_____, to contact the above named physician if my child has a medical emergency. I understand that if my child's physician is not available, another physician may be contacted on an emergency basis. I also give my consent for the child care provider to seek medical attention in an emergency at

Birth date:_____ Emergency Tel:_____ Emergency Tel:_____

_____. I will be responsible for all medical charges.
or walk -in clinic)

X_____ Signature

_____ Printed Name