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 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

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, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base 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): Zoe Rieder
Birth Date: 9/28/9
☐ Male ☒ Female

Address (Street, Town and ZIP code): 21 Porchester ln Riverside CT 06878

Parent/Guardian Name (Last, First, Middle): Lauren Rieder
Home Phone: 917-841-9744
Cell Phone:

School/Grade: Eastern Middle / 6th grade
Primary Care Provider: Greenwich Pediatrics

Race/Ethnicity: ☐ American Indian/Alaskan Native ☐ Hispanic/Latino ☐ Black, not of Hispanic origin ☒ White, not of Hispanic origin ☐ Asian/Pacific Islander ☐ Other

Health Insurance Company/Number* or Medicaid/Number*: Cigna

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 1 — 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.

Question			Question			Question		
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.

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 health care 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: [signature] Date: 4/20/21

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 09·28·2009 Date of Exam 12·29·2020

❑ 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** 55.5 in. / ____% ***Weight** 59 lbs. / ____% **BMI** 13.6 ____% **Pulse** ____ ***Blood Pressure** 90 / 62

	Normal	Describe Abnormal
Neurologic	✓	
HEENT	✓	
*Gross Dental	intact	
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	20/30	20/30

❑ Referral made

***Auditory Screening**

Type:	Right	Left
	☑ Pass ❑ Fail	☑ Pass ❑ Fail

❑ Referral made

	Date
History of Lead level ≥ 5µg/dL ☑ No ❑ Yes	
***HCT/HGB:** pending	
***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 Allergies ☑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source
*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
[signature]	12·30·2020	GREENWICH PEDIATRIC ASSOCIATES LLC ... AVENUE OLD GREENWICH, CT 06870 203 637-3212

Student Name: Zoe A. Rieder Birth Date: 09·28·2009 HAR-3 REV. 7/2018

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	*	*	See		Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*		Attached		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 the1st 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 the1st 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.

[signature]	12·30·2020	GREENWICH PEDIATRIC ASSOCIATES LLC ... GREENWICH, CT 06870 203-637-3212
Initial/Signature of health care provider MD / DO / APRN / PA	Date Signed	Printed/Stamped Provider Name and Phone Number

RIEDER, Zoe | DOB: 09-28-2009 | #7100

Vaccine List as of 12-30-2020

Diphtheria, Tetanus, Pertussis

Tdap	07-06-2020
DTaP	07-24-2014
DTaP	12-29-2010
DTaP	04-06-2010
DTaP	02-05-2010
DTaP	01-07-2010

Haemophilus Influenzae Type B

Hib, unspecified formulation	12-29-2010
Hib, unspecified formulation	04-06-2010
Hib, unspecified formulation	02-05-2010
Hib, unspecified formulation	12-09-2009

Hepatitis A

Hep A, ped/adol, 2 dose	10-07-2011
Hep A, ped/adol, 2 dose	03-31-2011

Hepatitis B

Hep B, adolescent or pediatric	07-14-2010
Hep B, adolescent or pediatric	11-11-2009
Hep B, adolescent or pediatric	10-12-2009

Influenza

influenza, injectable, quadrivalent, preservative free	10-08-2019
influenza, injectable, quadrivalent, preservative free	12-11-2018
influenza, injectable, quadrivalent, preservative free	12-06-2017
influenza, injectable, quadrivalent, preservative free	09-27-2016
influenza, live, intranasal	10-19-2015

Measles, Mumps, Rubella

MMR	11-15-2013
MMR	12-29-2010

Meningococcal

meningococcal MCV4P 07-06-2020

Pneumococcal

pneumococcal conjugate PCV 7 09-30-2010

pneumococcal conjugate PCV 7 04-06-2010

pneumococcal conjugate PCV 7 02-05-2010

pneumococcal conjugate PCV 7 12-09-2009

Polio

IPV 07-24-2014

IPV 03-31-2011

IPV 02-05-2010

IPV 01-07-2010

Rotavirus

rotavirus, unspecified formulation 04-06-2010

rotavirus, unspecified formulation 12-09-2009

Varicella

varicella 11-15-2013

varicella 09-30-2010