



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.

Please print

Name of Student (Last, First, Middle)		Birth Date	Sex
Address (Street)		Race/Ethnicity	
(Town and ZIP code)		<input type="checkbox"/> American Indian <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Other	
Home Telephone Number	School	Grade	
Name of Parent/Guardian (Last, First, Middle)			
Health Care Provider		Health Insurance Company/Number* or Medicaid/Number*	

* If applicable

If your child does not have health insurance, call 1-877-CT-HUSKY

Part I — To be completed by parent

**Important: Complete Part I before your child is examined.
Take this form with you to the health care provider's office.**

Please check answers to the following questions in columns on the left.
(Explain all "yes" answers in the space provided below.)

- | | Yes | No | |
|-----|--------------------------|--------------------------|--|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any concerns about your child's general health (overall eating and sleeping habits, teeth, etc.)? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Has your child been diagnosed with any chronic disease? <input type="checkbox"/> asthma <input type="checkbox"/> diabetes <input type="checkbox"/> seizure disorder <input type="checkbox"/> other _____ |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any allergies (food, insects, medication, latex, etc.)? |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child take any medications (daily or occasionally)? |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)? |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Has your child had any hospitalization, operation, major illness or injury, or significant accident? (Please specify.) |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | In the last 12 months, has your child experienced any difficulty with wheezing, excessive coughing or excessive night waking? (Please specify.) |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination? (Please specify.) |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have health insurance? (If your child does not have health insurance, call 1-877-CT-HUSKY) |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have dental insurance? |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | Would you like to discuss anything about your child's health with the school nurse? |

Please explain any "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian
Date

Date of Physical		NORTH BRANFORD PUBLIC SCHOOLS	Grade	
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PARENT'S PERMISSION FORM FOR ATHLETICS
2010 – 2011 SCHOOL YEAR

Athlete's Name: _____ Phone: _____
 Parent's Name: _____ Phone: _____
 Parent's Work Phone: () _____ or () _____

List the sports (Football, Soccer, VB, X-C, BB, etc.) that you are giving
 Permission for you child to participate in: **Do NOT just put an "X"**

Fall: _____ Winter: _____ Spring: _____

LIST any conditions that a coach should be aware of: _____

Date of last TETANUS Shot: _____

IN CASE OF EMERGENCY, Please contact one of the people listed below if a
 parent cannot be contacted/notified. **ALL** of the phone numbers listed below must
 be filled in **BEFORE** your child will be allowed to try-out or practice for a team.

Name: _____ Phone: _____ Relation: _____
 Name: _____ Phone: _____ Relation: _____

Hospital Preference : _____ Phone: _____
 Physician's Name: _____ Phone: _____
 Dentist's Name: _____ Phone: _____

I/We give permission for _____ (athlete's name) to participate in
 organized high school athletics for the current school year, realizing that such activity involves
 the potential for injury which is inherent in all sports. I/We acknowledge that even with the best
 coaching, use of the most advanced protective equipment and strict observance of rules, injuries
 can be so severe as to result in total disability, paralysis, or even death.

In case of emergency and I/We cannot be contacted, I/We give my/our permission
 for my/our child to receive medical attention.

Signature of Parent/Guardian: _____ **Date:** _____

(A xerox copy of this form will be carried by each coach to practice/contests)