



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.

Please print

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

Primary Health Care Provider: Race/Ethnicity options

Name of Dentist: Race/Ethnicity options

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

* 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.

Table with 3 columns of health history questions: Any health concerns, Allergies to food, Frequent ear infections, etc.

Developmental – Any concern about your child's:

Table with 3 columns of developmental concerns: 1. Physical development, 5. Ability to communicate needs, etc.

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:

All medications taken in child care programs require a separate Medication Authorization Form signed by an authorized prescriber and parent/guardian.

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