



State of Connecticut and YMCA Health Assessment Record



To Parent or Guardian:

In order to provide the best educational experience, our 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 medical advisor prior to participation in school, child care or camp. An immunization update and additional health assessments are required in the sixth or seventh grade and in the tenth or eleventh grade for schools. Specific grade level will be determined by the local board of education.

Please print

Name of Child (Last, First, Middle)	Social Security Number	Birth Date	Sex
Address (Street)	Race/Ethnicity		
Town and Zip Code	<input type="checkbox"/> American Indian	<input type="checkbox"/> White, not of Hispanic origin	
Home Telephone Number	<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic/Latino	
Name of Parent/Guardian (Last, First, Middle)	<input type="checkbox"/> Black, not of Hispanic origin	<input type="checkbox"/> Other	
Health Care Provider	School/Program	Grade	
	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, medications, 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 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 education needs in school, child care or camp.

Signature of Parent/Guardian

Date

PART II – MEDICAL EVALUATION

To the Health Care Provider: Please complete and sign.

Child's Name _____

Birth Date _____

has had a complete history and physical exam on _____ Month/Day/Year _____

FINDINGS FOR THIS CHILD ARE AS FOLLOWS:

Screening/Test Results			Immunization Record												
Note: *Mandated Screening/Text under Connecticut State Law			Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.												
*Height		BMI:	DOSE 1	DOSE 2	DOSE 3	DOSE 4	DOSE 5	DOSE 6							
*Weight:		*Postural:	DTP	*	*	*	*								
*Blood Pressure:		<input type="checkbox"/> Normal	DTP/Hib												
Pulse:		<input type="checkbox"/> Abnormal	DTaP												
*HCT/HGB:		Minimum _____	DT/Td												
Urinalysis:		Slight _____	OPV	*	*	*									
*Gross Dental:		Moderate _____	IVP	*	*	*									
Lead (Date/Result):		Marked _____	MMR												
		<input type="checkbox"/> Referral	Measles	*	*									Booster for entry into K and 7th grade	
TB and Other Test Results (Sickle Cell, etc.)			Mumps	*											
TB: In high-risk group? <input type="checkbox"/> Yes <input type="checkbox"/> No			Rubella	*											
TEST	DATE	RESULTS	HIB	*										Child under age 5	
			Hep B	*	*	*								Required for entry into K and 7th grade	
			Varicella	*										Child born 1/1/97 or later Required for 7th grade entry	
*Vision/Type of Screening		*Auditory/Type of Screening		PCV										Pneumococcal conjugate vaccine	
With glasses	R 20/	L 20/	Pass/Fail R	Other Vaccines (Specify)											
Without glasses	R 20/	L 20/	L												
Chronic Disease Assessment:			Disease Hx												
YES	NO		DATE OF ONSET	of above _____ (Specify) _____ (Date) _____ (Confirmed by)											
<input type="checkbox"/>	<input type="checkbox"/>	Asthma:	<input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe												
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> exercise induced <input type="checkbox"/> unclassified												
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes:	<input type="checkbox"/> Type I <input type="checkbox"/> Type II												
<input type="checkbox"/>	<input type="checkbox"/>	Anaphylactic reaction:	<input type="checkbox"/> food <input type="checkbox"/> insect <input type="checkbox"/> latex												
<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder:	_____	Exemption											
<input type="checkbox"/>	<input type="checkbox"/>	Other: Please specify:	_____	Religious _____ Medical: Permanent _____ Temporary _____ Date _____											
			Recertify Date _____ Recertify Date _____ Recertify Date _____												

This child has the following problems which may adversely affect his or her school, child care or camp experience:

Vision Auditory Speech/Language Physical Dysfunction Emotional/Social Behavior

The child has a health condition which may require emergency action at school, child care or camp, e.g. seizures, allergies, anaphylaxis. *Specify below.*

The child is on long-term medication. *Specify below.*

Comments and recommendations (additional information about any of the above health assessment): _____

The child may participate fully in the school, child care and camp programs including physical education activities.

The child may participate in the school, child care and camp program and physical education with the following restriction/adaptation.

(Specify reason and restriction) _____

Yes No Based on this comprehensive health history and physical examination, this child has maintained his/her level of wellness.

I would like to discuss information in this report with the nurse or first aid provider.

Signature of Health Care Provider	Name/Group Practice <i>(Please type or print)</i>	Phone Number



YMCA Camp Sloper

Medical Form Requirements

By State Regulation campers CANNOT attend camp until a medical form is on file at the camp office, preferably two weeks prior.

Please Note:

To be considered complete a medical form must include

- An Immunization record
- A date of physical exam within 36 months of the date that your child will begin attending camp.
- Signatures of the physician, physician’s assistant, or APRN and the parent.

If your child attended any of the following programs you may complete the form below to have the medical form copied for use at camp this summer if the date of physical exam is within 36 months of their start at camp and there have been no physical changes. **Return completed form to the front desk of either the Southington or Cheshire YMCA or mail to YMCA Camp Sloper at 1000 East Street, Southington, CT 06489.** This form is also available online at www.ymcacampsloper.org on the Parent page.

- YMCA Camp Sloper 2011
- Southington YMCA Learning Center Programs
- Southington YMCA School Age Child Care
- Cheshire YMCA Early Childhood or School Age Child Care Programs
- Cheshire YMCA Camp Quinnipiac 2011



Southington-Cheshire Community YMCAs

Request to Transfer Health Assessment Form

I request that a copy of the Health Assessment for my child _____

on file at _____ be forwarded to _____
(Program Name) (Program Name)

I believe that the medical information on the form is up-to-date, and that the physical is within the approved time frame for the program. If there have been any changes in my child’s health since the form was completed, I will complete a new Part 1 Parent Section of the Health Assessment Record and forward it to the new program. I acknowledge that it is my responsibility to provide accurate, complete, and up-to-date health information to insure the health and safety of my child.

Parent Name _____ Phone Number _____

Parent Signature _____