TO: +18603260552 P. 3

CHILD ENROLLMENT FORM

Date of Application: 5-1-18 Date of Enrollment: 5-1-18 Last Day of Enrollment:
Attention Provider: This information must be kept current at all times and shall be kept file for one year after the child ceases to be enrolled in the family child care home.
Child's Name: Everett Williams Child's Date of Birth: 3-7-18 Child's Address: 436 Roley Hill FE City: Covening Zip Code C6238
Mother's Name: Christian William Address: 436 Ryly Hill Rd City: Court Zip Code: 06238 Home Telephone #: (Cell #: (360) 830 - 5733 Emergency Contact # (560) 836 - 5733 e-mail Address: Courtest & gnal.com
Mother's Employer: KT+ Work #: (960) # 830 5133 Mother's Employer Address: 400 May 5+ CityE Hartford Zip Code 06
Father's Name: Plan Willing Address: 436 from Hill Address: 436 from Hill Address: 436 from Hill Address: 436 from Hill Address: 460 116-2833 Emergency Contact # (860) 916-2833 e-mail Address: Aman. T. Williams & Indina. Com Father's Employer: Address: 400 Main & City: Enhalted Zip Code 06
My Child's Weekly Child Care Schedule:
Monday 8-5 Sam - 5 pm Fuesday 8-5 Sam - 5 pm Friday Saturday Sunday
Signature of Parent or Guardian: Date: 4/17/23

TO: +18603260552 P. 4

CHILD ENROLLMENT FORM

Date of Application: 8-1-19 Date of Enrollment: 8-6-19 Last Day of Enrollment:
Attention Provider: This information must be kept current at all times and shall be kept file for one year after the child ceases to be enrolled in the family child care home.
Child's Name: Gavin Williams Child's Date of Birth: 6-6-19 Child's Address: 436 Riply All Pd City: County Zip Code 06:255
Mother's Name: Christian Williams Address: 436 Right Hill 22 City: Colenting Zip Code: 06256 Home Telephone #: (Cell #: (860) 830 - 373) Emergency Contact # (860) 830 - 5733 e-mail Address: Reoptiness gmall.com
Mother's Employer: Ptc Work #: (666) 830 - 5733 Mother's Employer Address: 400 MAIN St City: E. Hartford Zip Code OC
Father's Name: Ryan William) City: Could my Zip Code: 66238 Home Telephone #: (Cell #: (860) 916 - 2833 Cell #: (860) Pignation #: (860) Pignat
Father's Employer: PTF Work#: (860) 565 - 499) Father's Employer Address: 40 May St City: E. Hartford Zip Code 66
is в в в дань в в в и и дань в в повет в в в в в в в в в в в в в в в в в в
Monday Sam-Spm Tuesday Sam-Spm Thursday Sam-Spm Thursday Sam-Spm Friday Saturday Sunday
Signature of Parent or Guardian: Date: 1/17/23

TO: +18603260552 P. 5

CHILD ENROLLMENT FORM

Date of Application: 17-23 Date of Enrollment: 1-47-22 Last Day of Enrollment: 5/26/2023.
Attention Provider: This information must be kept current at all times and shall be kept file for one year after the child ceases to be enrolled in the family child care home.
Child's Name: Elorm Attimu Child's Date of Birth: Child's Address: 9t were street, also proserve Ct, Zip Code 0 6033
Mother's Name: Mana Address: Sane. City: Zip Code: Home Telephone #: (860) 774 3790 Cell #: () — Emergency Contact # () e-mail Address:
Mother's Employer: ST. Francis Borntel Work#: () Mother's Employer Address: 114 woodland St City: Hert ford Zip Code Oblig
Father's Name:
Father's Employer Address: 1277 man of 1 City: Spring Zip Code 0 1(03
му Child's Weekly Child Care Schedule:
Day(s)HoursMonday&-5Tuesday
Signature of Parent or Guardian: Date: 4// 25/23

7/2023 11:22 PM FROM: Staples TO: +18603260552 P.

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ATTIMU, Akorfa (id #207, dob: 08/11/2019)



State of Connecticut Department of Education 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 1) which will be helpful to the health care provider when he or she completes the health evaluation (Part 2) and oral health assessment (Part 3). 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.

			Pleas	e print					
Child's Name (Last, First, Middle): Attim	08/11/2019	Gender: F							
Address (Street, Town and ZIP code): 97	' Welr	St, G	lastonbury CT 06033	-2709				<u> </u>	
Parent/Guardian Name:(Last, First, Middl	le):			Home Phone: Cell Phone: (860) 794-3790 (860) 794-3790					
Early Childhood Program (Name and Pho	me Num	iber) :		Race/Ethnicity					
Primary Health Care Provider: None reco	rded			Black or Africa Latino	n Am	ericar	Not Hispanic or		
Name of Dentist;	n ueu		,						
	An dinata	113.1		J					·
Health insurance Company/Number or M Cigna U4971684505	/ledicald	vnum	per:				. , .		
Does your child have health insurance?	-	- ÇÝ	· ·	If your child doe	s not	have l	nealth insurance, call	1-877-CT-HUSKY	
Does your child have dental insurance?		Y) N						
Does your child have HUSKY insurance?	1	Y	(N)						
* If applicable									·
		Par	t I - To be complete	ed by paren	ıt/gu	ardi	ian.		
Please answer these	healt	th hi	istory questions al	hout vour c	hild	hef	ore the physic:	al examination.	
			'yes" or N if "no." Explain a	-					
Any health concerns	Y	N	Frequent ear infections	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Υ	N.	Asthma treatment	Y	W
Allergies to food, bee stings, insects	Υ	N	Any speech issues		Y	Ŋ	Seizure	Υ	N
Allergies to medication	Υ	N	Any problems with teeth		Υ	Ŋ	Diabetes	Y	N
Any other allergies	Y.	N			Y	N	Any heart problems	Ý	N
Any dally/ongoing medications	Υ	N	examination in the last 6 m				Emergency room vis	its Y	N_
Any problems with vision	Υ	N	Very high or low activity le	vel	<u> Y</u>	<u>, N</u>	Any major illness or	injury Y	N
Uses contacts or glasses	Υ	N			<u>Y</u>	<u> y</u>	Any operations/surge	eries Y	N_
Any hearing concerns	Y	N	Problems breathing or cou	gning	Υ	Ŋ	Lead concerns/poiso	oning Y	N_
Development	al - An	y co	ncern about your chil	d's:			Sleeping concerns	Υ Υ	N_
Physical development	Y	N	5. Ability to communicate r	needs	Y	N-	High blood pressure	Y	N/
2. Movement from one place	Y		6. Interaction with others		Y	- N	Eating concerns	Y	N
to another			7. Behavior	· · · · · · · · · · · · · · · · · · ·	Y	Ŋ	Toileting concerns	Y	Ŋ
3. Social development	Y	ĸ	8. Ability to understand		Υ	A	Birth to 3 services	Υ	N/
4. Emotional development	Y	Ŋ	9. Ability to use their hand:	8	Y	N	Preschool Special E	ducation Y	N_
Explain all "yes" answers or pro	vide a	nv a	dditional information:						
Have you talked with your child's primary	health c	are p	ovider about any of the abo	ove concerns?	Υ	N	NA		
Please list any medications your child will need to take during program hours:									
All medications taken in child care progra	ms requ	ire a :	separate Medication Au	ıthorization F	ôrm,	signe	d by an authorized pre	sscriber and parent/gua	rdian.
I give my consent for my child's health ca	are prov	ider a	nd early childhood provide	r /		4	62	4/27/23	

ED 191 REV. 10/2018 C.G.S. Section 10-16q, 10-206, 19a.79(a), 19a-87b(c); P.H. Code Section 19a-79-5a(a)(2), 19a-87b-10b(2); Public Act No. 18-168.

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.

7/2023 11:22 PM FROM: Staples TO: +18603260552 P.



State of Connecticut Department of Education 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.

an early childhood program in Conne	cticut.				•		_		
		Please	e print						
Child's Name (Last, First, Middle)	rfa		Birth Date	Birth Date (mm/dd/xyyy) 9 Male Memale					
Address (Street, Town and ZIP code)	treet	- alaston	bury	CT	106033		***************************************		
Parent/Guardian Name (Last, First, 1	Middle)		Home Pho	ne	Cell Phone	+ 3-	79		
Early Childhood Program Name as		ther)	Race/Ethn	•	an/Alaskan Native 🖸 Hispanic/I	Latino			
Primary Health Care Provider:	. 1	,	Black,	not of F	Hispanic origin Asian/Pac Hispanic origin Other		nder		
Name of Dentist: FIG Health P	'ad								
Health Insurance Company/Num	o er* or Med	dicaid/Number*							
Does your child have health insur Does your child have dental insur Does your child have HUSKY ins	ance?	N If	your child does	not hav	e health insurance, call 1-877-C7	r-HŲSI	KY		
* If applicable	· · · · · · · · · · · · · · · · · · ·								
	Part	I — To be complet	ed by parent	/guar	dian.				
Please answer these h		-		_	ore the physical examina	tion			
		or N if "no." Explain	•		* *	+1011.			
		*			* *				
Any health concerns	Y N	Frequent ear infections	Y	N	Asthma treatment	Y	N_		
Allergies to food, bee stings, insects	Y	Any speech issues	<u>Y</u>	Ŋ	Seizure	Y	<u>N</u>		
Allergies to medication	Y N	Any problems with teet		<u>}</u>	Diabetes	Y	N-		
Any other allergies	Y N	Has your child had a de			Any heart problems	Y	N.		
Any daily/ongoing medications	Y N	examination in the last		Ŋ	Emergency room visits	Y	N		
Any problems with vision	Y M	Very high or low activit		N_	Any major illness or injury	Y	Ŋ		
Uses contacts or glasses	Y X	Weight concerns	Y	Ŋ	Any operations/surgeries	Y	N.		
Any hearing concerns	Y M	Problems breathing or c	oughing Y	Ŋ	Lead concerns/poisoning	Y	Di-		
Development	al Any co	oncern about your child'	s:		Sleeping concerns	Y	N		
Physical development	Y N	5. Ability to communic	ate needs Y	N	High blood pressure	Y	Ŋ		
2. Movement from one place		6. Interaction with other	ers Y	N	Eating concerns	Y	Ŋ		
to another	Y N	7. Behavior	Y	N.	Toileting concerns	Y	Ŋ		
3. Social development	Y N	8. Ability to understand	i Y	Ŋ	Birth to 3 services	Y	Ŋ		
4. Emotional development	Y N	9. Ability to use their h	ands Y	Ŋ	Preschool Special Education	Y)Ji-		
Explain all "yes" answers or provide	le any addit	tional information:							
Have you talked with your child's pri	mary health	a care provider about any	of the above conc	erns? \	N PIA				
Please list any medications your chil will need to take during program hou									
All medications taken in child care progre	ıms reguire a s	separate Medication Authori	zation Form signed	by an au	thorized prescriber and parent/guardian				
I give my consent for my child's healt childhood provider or health/nurse consu			511.	······································	41251	23			
the information on this form for confid	dential use in	meeting my	OF POLICY				T\. :-		
child's health and educational needs in the	ic early childh	ioua program. Signature	of Parent/Guardia	u.			Date		

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ATTIMU, Akorfa (id #207, dob: 08/11/2019)

REV. 10/2018

Part II - Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name: Akorfa Attimu I have reviewed the health history informs	ation provided in Part I of this form	Birth Date: <u>08</u>	11/2010	Date of 6	Exam: 10/13/2022	
hysical Exam	audit provided at Part (0) and forth				***************************************	
ote: "Mandated Screening/Test to be com	polated by provider					
	protect by protects.					
itais						
Ht: 38.9 in (98.81 cm; 8		: 12 10/13/2022 ()4:04 pm	Ŧ	98.3 F* (36.83 C)	
%ile) 10/13/2022 (pm	U-7.U-7				10/13/2022 04:04 pm	
•						
Wt: 37 lbs 6.4 oz (16.96	3 kg; BMI:	: 17.4 (89th %ile: A		Pulse	: 98 bpm 10/13/2022 04:0	
91st %ile) 10/13/20 04:03 pm	U22	sex) 10/13/2022 pm	1 04:04		þm	
04.00 pm		pm				
creenings						
/Islon Screening	*Hearing Screening			*Anemia: at 9 to 12 m	onths and 2 years	
EPSDT Subjective Screen Completed	D EPSDT Subjective	Screen Completed		ļ		
Birth to 3 yrs)	(Birth to 4 yrs)					
EPSDT Annually at 3 yrs	C EPSDT Annually at			*Hgb/Hct:	* Date	
Early and Periodic Screening.	(Early and Periodic S			11Best 14-4	1 7815	
Diagnosis and Treatment)	Diagnosis and Treatm			*Lead: at 1 and 2 year	uni V na maudi	
/pe: <u>Rknht Le</u> With glasses 20/ 20	<u>eft</u> Type: ^/	Right D Pass	<u>Left</u> □ Pass	screen between 25 - 7	=	
Without glasses 20/ 20		□ Fall	□ Fell	Selecti Dollicoli 20 - I	€ 11KA NI 10	
Unable to assess	Unable to assess			History of Lead level		
Referral made to:	☐ Referral made to: _			≥5µg/dL ETNo □Y	9 \$	
		·		*Result/Level:	* Data	
B: High-risk group? ETNo ☐ Yes	*Dental Concerns: ¿	No ☐ Yes		ResulvLeves.	Date	
est done: Di No Di Yes Date:	☐ Referral made to:			į		
	Has this child received					
esults:	the last 6 months?	No Pive				
antmant.		10 103		Other:		
	_mv-			Other:		
Developmental Assessment: (Birth - 5 ye	ars) 🗆 No 🗗 Yes Type:			Other:		
Developmental Assessment: (Birth – 5 yellosults: WWC		ntuncipa				
Developmental Assessment: (Birth – 5 years)		ntuncipa			ED	
Developmental Assessment: (Birth - 5 yell esults: WWC MMUNIZATIONS I Up to Date	ars) □ No ☑ Yes Type: or □ Catch-up Schedule: MUS	ntuncipa			ED	
Developmental Assessment: (Birth - 5 year esults: WWC MMUNIZATIONS Up to Date Chronic Disease Assessment:	or Catch-up Schedule: MUS	THAVE IMMUN	IZATION	RECORD ATTACH		
Developmental Assessment: (Birth - 5 years Birth - 5 years Birth - 5 years Birth - 5 years Birth - 5 years MMUNIZATIONS Development Up to Date Chronic Disease Assessment: Sthma	or C Catch-up Schedule: MUS	THAVE IMMUN	IZATION	RECORD ATTACH		
Bevelopmental Assessment: (Birth - 5 years the saults: WW - 5 years the saults: WW - 5 years the saults: WW - 5 years the saults that saults the saults the saults that saults the saults that saults the saults the saults the saults the saults the saults that saults the saults th	or C Catch-up Schedule: MUS ttent C Mild Persistent C ean Asthma Action Plan	THAVE IMMUN Moderate Persister	IZATION	RECORD ATTACH		
Developmental Assessment: (Birth - 5 years baults: WW - 1 Up to Date 1 Up to Date 2 Up to Date 2 Up to Date 2 Up to Date 3 Up to Date 4 Up to Date 4 Up to Date 4 Up to Date 5 Up to Da	or C Catch-up Schedule: MUS	THAVE IMMUN Moderate Persister	IZATION	RECORD ATTACH		
Bevefopmental Assessment: (Birth - 5 years at least the second of the se	or C Catch-up Schedule: MUS ttent C Mild Persistent C ean Asthma Action Plan	THAVE IMMUN Moderate Persister	IZATION	RECORD ATTACH		
Developmental Assessment: (Birth - 5 yellesults:	or Catch-up Schedule: MUS Ittent Mild Persistent Han Asthma Action Plan I in child care setting: No	THAVE IMMUN Moderate Persister	IZATION	RECORD ATTACH	ercise induced	
Developmental Assessment: (Birth - 5 years and the control of the	or	THAVE IMMUN Moderate Persister Yes:	IIZATION al 🗆 Sev	RECORD ATTACH	ercise induced	
Internation Property Property	or	THAVE IMMUN Moderate Persister Yes:	IIZATION at Sev	RECORD ATTACH	ercise induced	
Internation Property Property	or	THAVE IMMUN Moderate Persister Yes: Insects Late	IIZATION at Sev	RECORD ATTACH	ercise induced	
Interpretation of the provider	or Catch-up Schedule: MUS Itent Mild Persistent In Asthma Action Plan In child care setting: No Yes No Yes: Food In Emergency Allergy Plan Type II Other Ch	THAVE IMMUN Moderate Persister Yes: Insects Late Infonic Disease:	IIZATION Sev	RECORD ATTACH	ercise induced	
No Yes History/risk of Anaphylaxis: Yes History/risk of Anaphylaxis: History Yes Type teleprocess Yes Yes Yes Type teleprocess Yes Ye	ttent	THAVE IMMUN Moderate Persister Yes: Insects Late Infonic Disease:	IIZATION Sev	RECORD ATTACH	ercise induced	
Internity of the child has a developmental Assessment: (Birth - 5 years and the child has a developmental delay/disable control of the child has a developmental delay/disable c	or	THAVE IMMUN Moderate Persister Yes: Insects Late Insects Late Insectional experientional/Social Late at the program.	IIZATION Sevential Me	RECORD ATTACH vere Persistent Exe	ercise induced source	
Internation Part Pa	ttent	THAVE IMMUN Moderate Persister Yes: Insects Late Insects Late Insectional experientional/Social Late at the program.	IIZATION Sevential Me	RECORD ATTACH vere Persistent Exe	ercise induced source	
MMUNIZATIONS Up to Date Chronic Disease Assessment: Sthma No Yes Internit If yes, please provide a copy of Rescue medication required History/risk of Anaphylaxis: If yes, please provide a copy of History/risk of Anaphylaxis: If yes, please provide a copy of History/risk of Anaphylaxis: If yes, please provide a copy of Internit yes, please provide a copy of Int	ttent	THAVE IMMUN Moderate Persister Yes: Insects Late Insects Late Insectional experientional/Social Late at the program, e.g., s	IZATION Sevential Me Inco: Behavior pecial diet,	RECORD ATTACH vere Persistent	ercise induced source	
Developmental Assessment: (Birth - 5 years esults:	ttent	THAVE IMMUN Moderate Persister Yes: Insects Late Insects Late Insectional experientional/Social Late at the program, e.g., s	IZATION Sevential Me Inco: Behavior pecial diet,	RECORD ATTACH vere Persistent	ercise induced source	
Chronic Disease Assessment: sthma	ttent	THAVE IMMUN Moderate Persister Yes: Insects Late In Ironic Disease: Educational experie Disonal/Social Late at the program. The program, e.g., s poses a risk to oth	IZATION Sevente Me Ince: Behavior pecial diet,	RECORD ATTACH vere Persistent	ercise induced source	
Developmental Assessment: (Birth - 5 yellesults:	ttent	THAVE IMMUN Moderate Persister Yes: Insects Late In Ironic Disease: Educational experie Disonal/Social Late at the program. The program, e.g., s poses a risk to oth	IZATION Sevente Me Ince: Behavior pecial diet,	RECORD ATTACH vere Persistent	ercise induced source	
Developmental Assessment: (Birth - 5 yellesults: WWW. IMMUNIZATIONS	ttent	THAVE IMMUN Moderate Persister Yes: Insects Late Insects Late Insectional experientional/Social at the program. The program, e.g., social poses a risk to other, this child has man	IZATION Sevent	RECORD ATTACH /ere Persistent	source mergency	
Developmental Assessment: (Birth - 5 yellesults: WWW. MMUNIZATIONS Up to Date: Chronic Disease Assessment: sthma Wo Yes Intermit If yes, please provide a copy of Intermit Rescue medication required: If yes, please provide a copy of Intermit History/risk of Anaphylaxis: Intermit If yes, please provide a copy of Intermit	ttent	THAVE IMMUN Moderate Persister Yes: Insects Late Insec	IZATION Sevent	RECORD ATTACH /ere Persistent	source mergency participate safety in the	
Developmental Assessment: (Birth - 5 yellesults: WWW. IMMUNIZATIONS	ttent	THAVE IMMUN Moderate Persister Yes: Insects Late Insec	IZATION Sevent	RECORD ATTACH /ere Persistent	source mergency participate safety in the	

4/27/2023 11:22 PM FROM: Staples TO: +18603260552 P.

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ATTIMU, Akorfa (id #207, dob: 08/11/2019)

Signature of health care provider DMD / DDS / MD / DO / APRN / PA / RDH

Date Signed

Printed/Stamped Provider Name and

Phone Number

TO: +18603260552

FIG HEALTH PEDIATRICS LLC • 55 Nye Rd, Suite 105, GLASTONBURY CT 06033-2061

ATTIMU, Akorfa (id #207, dob: 08/11/2019)

Part 3 — Oral Health Assessment/Screening Health Care Provider must complete and sign the oral health assessment.

HAR-3 REV. 7/2018

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, Fir	st, Middle)		Birth Date	Date of Exam
Attimu Akorfa			08/11/2019	10/13/2022
School			Grade	Sex:
Home Address				<u> </u>
97 Weir St				
Glastonbury, CT 06033	-2709			
Parent/Guardian Name (Last, First, Middle)		Home Phone	Cell Phone
			(860) 794-3790	(860) 794-3790
Dental Examination	Visual Screening	Normal		Referral Made:
Completed by:	Completed by:	₽Yes		☐ Yes
☐ Dentist	(3/MD/DO	□ Abnorm	al (Describe)	LHO
	□ APRN			
	□ PA			
	☐ Dental Hyglenist		· · · · · · · · · · · · · · · · · · ·	*
			· • • • • • • • • • • • • • • • • • • •	
Risk Assessment			Describe Risk Fac	tors
□ Low	☐ Dental or orthodontic	: annliance		☐ Carjous lesions
☐ Moderate	☐ Saliva	o appliance		□ Restorations
☐ High	☐ Gingival condition			☐ Pain
	☐ Visible plaque			□ Swelling
	☐ Tooth demineralizati			
	1			☐ Trauma
	☐ Other			□ Other
give permission for rele	nealth care provider: ase and exchange of informs s health and educational ne	mation on this fo		nurse and health care provider for confidentia
Signature of Parent/Gua	rdian			D
Electronically Signed by:	MANUEL A. ORTA COBO), MD	04/27/2023	

7/2023 11:22 PM FROM: Staples TO: +18603260552 I

Fax Server

2/10/2022 11:29:13 AM PAGE 16/029 Fax Server

ProHealth Physicians

3 Farm Glen Farmington,CT 06032 (860) 284-5200

> Putient: Attimu, Akorfa EMRN: 9229930 OATRN: 9229930



Ages 1 year DOB: 08/11/2019 Homes (860) 794-3790

Immunization Series Record

	1	mmunizai	non Series Recor	'a	
immunization	Brand Name	Series #	Date (Age)	Status Type	Annotations
DTP/DTaP		1	15-Nov-2019 (3 mo.)	Admin	
DTP/DTaP		2	12-May-2020 (9 mo.)	Admin	
DTP/DTaP		3	16-Jul-2020 (11 mo.)	Admin	
Hepatitis B		1	19-Jun-2020 (10 mo.)	Admin	
Hepatitis B		2	10-Sep-2020 (12 mo.)	Admin	
HIB		1	10-Jan-2020 (4 mo.)	Admin	
HIB		2	29-May-2020 (9 mo.)	Admin	
HIB		3	10-Sep-2020 (12 mo.)	Admin	
PCV		1	29-May-2020 (9 mo.)	Admin	
PCV		2	10-Sep-2020 (12 mo.)	Admin	
Polio		1	10-Jan-2020 (4 mo.)	Admin	_
Pollo		2	12-May-2020 (9 mo.)	Admin	
Polic		3	16-Jul-2020 (11 mo.)	Admin	AN
				<u></u>	

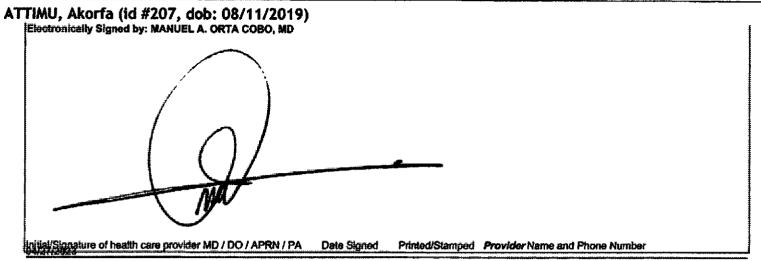
?rinted By:

de Melo, Elisa

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Vaccine Type	es Date	Age	Amt.	Route	Site	NDC	Lot#	Mfr.	Exp.	VIS	VIS Given	Vaccinator
Diphtheria, Tetar	nus, Perti	ussis				**.						<u> </u>
DTaP	02/21/22	2y6mo	0.5 ml.	Intramuscular	Deltoid, Right	58160081043	4L9E4	GlaxoSmithKline	02/07/23	DTaP 08/06/2021		Manuel Orta cobo, MD
Hepatitis A						•						
Hep A, ped/adol, 2 dose	02/21/22	2y6mo	0.5 mL	Intremuscular	Deltoid, Left	00006409501	T033304	Merck and Co., Inc.	04/02/22	Hepatitis A 10/15/2021	02/21/22	Manuel Orta cobo. MD

TO: +18603260552 P. 13

TIMU, Akorfa (id Child's Name: <u>Akorfa Atl</u>		11/2019)	Birth Date:	08/11/2019	RI	EV. 10/2018
Vaccine (Month/Day/Year			Inization Rec ler: Please com		ial below.	one and the later of the later
	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/QPV						
MMR						
Measles						1
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella				*****		
PCV* vaccine					*Pneumococcal	conjugate vaccin
Rotavirus			····			
MCV**					**Meningococcal	conjugate vacci
Flu						1
Other						

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

† Recertify Date

· · · · · · · · · · · · · · · · · · ·	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	16-18 months of age	By 19 months of age	2 years of age (24-35 mos.)	3-5 years of age (36-59 mos.)
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 birthday1	1 dose after 1st birthday1	1 dose after 1st birthday1	1 dose after 1st birthday1	1 dose after 1st birthday1
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 given3	1 booster dose after 1st birthday4	1 booster dose after 1st birthday4	1 booster dose after 1st birthday4	1 booster dose after 1st birthday4	
Varicella	None	None	None	None	None	None	1 dose after 1st birthday or prior history of disease1.2	1 dose after 1st birthday or prior history of disease1.2	1 dose after 1st birthday or prior history of disease1,2
Pneumococcal Conjugate Vaccine (PCV)	None	1 doșe	2 doses	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 birthday5	1 dose after 1st birthday5	1 dose after 1st birthday5	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

† Recertify Date

- 2. Physician diagnosis of disease
- 3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacei)

† Recertify Date

- 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 on or after January 1, 2009
- 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

27/2023 11:22 PM FROM: Staples TO: +18603260552 P.

FIG HEALTH PEDIATRICS LLC • 55 Nye Rd, Suite 105. GLASTONBURY CT 06033-2061

ATTIMU, Akorfa (id #207, dob: 08/11/2019)

Electronically Signed by: MANUEL A. ORTA COBO, MD

04/27/2023

Signature of health care provider MD / DO / APRN / PA

Date Signed Printed/Stamped Provider Name and Phone Number



State of Connecticut Department of Education Early Childhood Health Assessment Record



(For children ages birth -5)

To Parent or Guardian: In order to provide the best experience, early childbond providers me and a sour child's health needs. This fit	11412
requests information from you (Part I) which will be helpful to the health care provider when he of some some health evaluation (Part II) S	
law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered masse, a physician assistant, a	OF,
logally qualified practitismer of medicine, an advanced practice registered muse or a physicion assistant statismed at any military have prior to enter	rin;
an early childhood program in Connecticat	,

Please print Child's Name (Last, First, Middle) Birth Date (omiskervery) Male I Fensale Williams, Gavin Scott 06/06/2019 Address (Street, Tirwn and ZIP code) 436 Ripley Hill Road Coventry, CT 06238 Parent/Guardian Nume (Last, First, Middle) Home Phone Cell Phone Williams, Christina 860-830-5733 860-830-5733 Early Childhood Program (Name, and Phone Namber) Race/Ethnicity Mnn Gilnack Daycare 6330416 American Indian/Alaskan Native U Hispanic/Latina Primary Health Care Provider: Black, not of Hispanic origin. Asian/Pacific Islander Frank Bush MD Name of Denlist 5 miles for the Future 🔏 White, not of Hispanic origin □ Other Health Insurance Company/Number* or Medicaid/Number* UQK197W10857 Blue Cross - Blue Care \$00.00 Does your child have health insurance? Does your child have dental insurance? If your child does not have health insurance, call 1-877-CT-HUSKY Does your child have HUSKY insurance? . 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. Any health concerns Frequent car intections Asthma ice atment Allergies to food, bee stings, insects Any speech issues Scizure Allergies to medication Any problems with teeth Y Diabetes ¥ Any other allergies His your child had a dental Any heart problems ()examination in the last 6 menths Any daily/ongoing medicanons Ν Y Emergency room visits ¥ Very high or low activity level Any problems with vision Y Any major illness or injury Uses connects or glasses Weight concerns Y Any operations/surgenes Any hearing concerns Problems breathing is coughing Lead concerns/poisoning Any concern about your child's: Sleeping concerns Developmental ---1. Physical development High blood pressure 5. Ability to communicate needs Eating concerns 6. Interaction with others 2. Movement from one place to another Y Toileting concerns Y 7. Behavior ĭ 3. Social development Ý 8 Ability to understand Birth to 3 services 4. Emotional development 9. Ahility to use their hands Preschool Special Education 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." Please list any medications your child will need to take during program hours: All medications token in child care programs remains a separate Medication Authorization Form signed by an authorized prescriber and parentigmanium I give my consent for my child's health cure provider and early childbood provider or health/nurse consultant/coordinates to discuss the information on this form for confidential use in meeting my

child's health and educational needs in the early childhood program

Health Care Provider must complete	Part II — Medical Evaluation and sign the medical evaluation, physical	
		06/2019 Date of Exam 5/19/22
		nauddyygy) (mudddyyg)
Physical Exam Oute: Mandated Screening/Test to be complete T392 when 83 4 Weight \$C ths. Creenings Vision Screening I EPSIT Subjective Screen Completed (Birth to 3 yrs) I EPSIT Annually at 3 yrs	02/82 5 BM 16/60 % MC_	acm (4 *Blood Pressure (20) ; (20) - 24 months) (Annually at 3 - 5 years) *Anemia; at 9 to 12 months and 2 years
(Early and Periodic Screening, Diagnosis and Treatment) ypc: Set Secur Right Leit With glasses 20/ 20/ Without glasses 20/ 20/ Unable to assess J. Keferral made to:	(Early and Periodic Secreting. Diagnosis and Treatment) Type: Right Left HH APass Thuss BITH Alfail A Fait A Unable to assess A Referral analyte to	*Lead: at 1 and 2 years: if no result screen between 25 - 72 months History of Loudlevel - 5µg/dL. I No. I Yes
TB: High-risk gruup? ZNo Q (es Test done: Q No Q Yes Date desults: Treatment:	Dental Concerns UNa U Yes U Referral mode to: Has this child received dental care in the last 6 months? UNo UYes	"Result/Level 'Date 3.5 ugldL (\$2.3\7c) Other:
Chronic Discuse Assessment: Asthma	In child care setting: U No U Yes U No U Yes U No U Yes U No U Yes: U Food U Insects U Late	
Diabetes Solution Of Yes, Of Type I Seizures Solution Of Yes: Type:	(4) Type II Other Chronic Disease	
 Vision (1) Auditory (1) Speech/Lang This child has a developmental delay/disab This child has a special health care need wf medication, history of contagious disease. S 	h may adversely affect his or her educational exper- mage. If Physical II Emonogal/Social II Bet office that may require intersention at the program, such may require intervention at the program, e.g., sp pecifs:	nence Savior pecual dict, hong-term/ongoing/daily/Amengency
sately in the program. No 27 Yes Based on this comprehensive has been a Yes. This child may fully participate.		ntained his/her level of wellness.
J No May Yes Is this the child's medical hom	e in the program with the following testrictions/adap re? Unit I would like to discoss information in this a and/or ourse/bealth consultant/coordinator.	report with the early childhood pro-ider
R. Pemberton mo	8-18-32	27 Hilant Stragt Mandwater GT 68940 (860)541-3903
signature of bealth care provider MD/DO/APRNAP.	A Date Signed	Primod/Stamped Provider Name and Phone Number

11:22 PM FROM: Staples

TO: +18603260552

Child's Name: Gavin Williams Birth Date: <u>06/06/2019</u>

REV. 3:2015

Immunization Record

To the Health Care Provider: Please complete and initial below.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT	08/08/19	10/09/19	12/11/19	09/10/20	Marin High Co. Marin Co.	
IPY/OPV	08/08/19	10/09/19	12/11/19			
MMR	06/23/20		4			Yes endingthing martine, state catalogues amount surgen to
Measles	Carlo de la companio de presidente de la companio del companio del companio de la companio del la companio de la companio del la companio de	tiri, 1944 tiri, 4 vilora mala dia manana anta manana manana anta manana anta manana anta manana anta manana a	nde yf ffraif anlaif a blefannen mae'n aerill, anna aug aur aer genauffer a hywryw afdam weni 	######################################		ad v a relier i pyrawych ddyddyndyddyd dyn nywyddyn addiadau
Mumps	Water Contract of the Contract		ali terreta di distributa di Periodi di Peri		<u> </u>	90 to - 720 to the management
Kubella		Tour self-trans and Audition and Audition of the Self-transport			and an experience of the contract of the contr	
HII)	08/08/19	10/09/19	09/10/20	Annual State Control of the State of the Sta	n oordinamen area area area na marka area na marka na ma Tangan na marka na m	to an order the order of an area decree
Hepatitis A	06/23/20	02/19/21		the latest and the second of t		M. PROP Military with the second construction and the s
Hepatitis B	06/06/19	08/08/19	10/09/19	12/11/19	na constitut formati esta filialmente esta cina pri per manga per per persona per constitui casa per la	
Varicella	06/23/20	в фототого да постоя выстана на постоя н -		THE THE PROPERTY AND ADDRESS OF THE PROPERTY O	t out the of the man and an account of the transmission of the contract of the	Maritim M. Million Hady-convey by the bit had an
PCV ^a vaccine	08/08/19	10/09/19	12/11/19	09/10/20		
lotavirus	08/08/19	10/09/19	12/11/19			
MCV**				3	**Meningococcal con	jugale vaccinc
Influenza	12/11/19	03/10/20	09/10/20	10/22/21		
Tdap/Td				*		
	- 1/4/1/10 - 1/20 - 1/20 - 1/20 - 1/20 - 1/20 - 1/20 - 1/20 - 1/20 - 1/20 - 1/20 - 1/20 - 1/20 - 1/20 - 1/20 -	the Charles of the Ch	elle make, menerolekseksekse kalkurik kalkurik kalkurik kalkurik menerik menerik kalkurik kalkurik kalkurik ka Per menerik kelon Menerik, menerolekseksekseksekseksekseksekseksekseksekse		ersersformen von und Method und de Andreis von der von	
Discase history I	or varicella (chickenpo			***************************************		
		(D)	atc)		(Confirmed by)	
Exemptions	Religious	Medical: P	erunnent	†Temporary	Date	
	TRecentify Date	*Recentify I	Date	‡Recently Date		

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	lly .) months of age	By 5 months of age	By 7 mooths of age	By 16 months of age	16-18 months of age	By 19 months of age	2 years of age (24-35 mas.)	3-5 years of age (36-59 mos.)
OTPOTRIY DT	None	dose	Lyses	3 doss	1 (14.5.4	3 doses	4 doses	4 děsts	4 doses
Polic	None	dose	2 deses	÷ ก่องเร	2 dines	2 doses	3 doses	3 dayes	1 doses
MMR	None	None	None	None	t dose after Ist birthday'	I dose after for birthday	l dose after 1st birthday	I dose after list builtelay?	l dose after Isi birthday!
Hep B	None) dose	2 denos	2 deses	2 doses	2 doses	Miloses	કે લેવલલ	4 doses
1113	None	likise	2 denes	2 or 3 doses depending on vaccing given?	Foodster dase after Est buthday*	I belower dose ofter Isi birthday*	1 bouster dose after 1st biuhday'	I boosier desc áltér fst birthday	Ebaosier dose after 181 biziliday
Varicella	None	None	None	None	I dusc after (st birthday or poor history of disease)	I dose after Ist birthday or prior history of disease's	I directafted lat histology in pronthistory of disease?	l dose after let birriday or prior history of disease	I dose airer I sa biahday or prior history of disease
Pneumococcal Conjugate Vaccine (PCV)	Noik	1113C	· Literature and the second se	3 vloves	l couse after 15t birthday	t dose siter Est birthday	l dose after Ist bathday	t dose after En birthday	Edose after Est birthday
Hepatitis A	None	None	Nun	None	l dose after Lst bioliday!	Lidose after Est birthday!	L dose after Lst hathday!	2 dases given 6 mondes apar	I doses given 6 munths apart
Influenza	None	None	None	For 2 doses	Lor 2 doses*	1 or 2 doses*	1 or 2 doses	Lor 2 doses	In 2 diver

if it aboratory confirmed termonity also acceptable

27 Histard Streat Manchester CT 06040 :8001648-3P03

 R. Pemberton no

Physician diagnosis of disease

s. A complete primary series is I doses at PRP-CMP (Pads axHill) or 3 doses at Hill (Acithi or Feducal).

^{4.} As a final booster dose if the child completed the primary series before age 12 months. Children who recover the first dose of Hib on or when 12 months of age and before 45 months of age. It is required to have 2 direct. Children who received the first done of Hib nacrons on offer 15 as other of age are required to have only one dose

^{5.} Hepatitis Ass required for all children hum on or after January 1, 2009.

^{6.} Two doses in this same his sensor are required for children who have not previously received an adherize caremation, with a single dose required during subsequent sensors. From J. Boath MO. PC

4/27/2023 11:22 PM FROM: Staples TO: +18603260552



State of Connecticut Department of Education **Health Assessment Record**



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 physi-

cian 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.

Student Name (Last, First, Middle) Williams, Everett			I Litretto Illuta	LiNEMAL A CENTRAL	1
			Birth Date 03/07/2018	Male 🔾 Fer	nate
Address (Street, Town and ZIP code)			100/07/2010		
436 Ripley Hill Road C	oventry	CT 06238			
Parent/Guardian Name (Last, First,	Middle)	, 01 00200	Home Phone	Cell Phone	
Williams, Christina	nadic,		860-830-57		733
School/Grade			Race/Ethnicity	☐ Black, not of Hispa	
			American Inc		
Primary Care Provider			Alaskan Nati		
Ann Gilnack Do	WOUNT	_	☐ Hispanic/Lati	no 🚨 Other	
Health Insurance Company/Num	ber* or Me	edicaid/Number*			
Blue Cross - Blue Care \$00		UQK601M63347			
Does your child have health insu Does your child have dental insu		N If you	r child does not ha	ive health insurance, call 1-877-0	CT-HUSKY
* If applicable					
	Part 1	- To be completed	l by parent/gu	ardian.	
Please answer these hea					nination
		or N if "no." Explain all '			111111111111111111111111111111111111111
					· · · · · · · · · · · · · · · · · · ·
Any health concerns	Y/N	Hospitalization or Emergency		Concussion	Y <u></u>
Allergies to food or bee stings	Y M	Any broken bones or disloc		Fainting or blacking out	Y N
Allergies to medication	Y X	Any muscle or joint injurie		Chest pain	Y (N)
Any other allergies	Y (N)	Any neck or back injuries	Y (N	Heart problems	Y (N)
Any daily medications	Y	Problems running	Y (N)	High blood pressure	Y N
Any problems with vision	Y	"Mono" (past 1 year)	Y (N)	Bleeding more than expected	Y
Uses contacts or glasses	Y N	Has only 1 kidney or testic		Problems breathing or coughing	Y (N
Any problems hearing	Y	Excessive weight gain/loss		Any smoking	YN
Any problems with speech	YCN	Dental braces, caps, or brid	lges Y	Asthma treatment (past 3 years)	Y ()
Family History				Seizure treatment (past 2 years)	Y (N
Any relative ever have a sudden une		•	Y N	Diabetes	Y
Any immediate family members have			YN	ADHD/ADD	Y (N
Please explain all "yes" answers	nere. For il	lnesses/injuries/etc., includ	le the year and/or	your child's age at the time.	
				, , , , , , , , , , , , , , , , , , , ,	
Is there anything you want to disc	cuss with the	ne school nurse? YW	If yes, explain:		
Please list any medications your			•	~ ~ ~	
child will need to take in school:		Λ	•		
All medications taken in school requi	re a senara	w Medication Authoritation	Form sinned by a bo	alth care provider and parently and	·
rega	, o a acpura	- Intaleanon Anthorication	i orm signed by a ne	aan care provinci ana parenirgiara	un.
		10 7			
I give permission for release and exchange between the school nurse and health car					3/13/2003

Part 2 — Medical Evaluation

HAR-3 REV. 7/2018

					e medical evalua			
Student Name Everel					Birth Date <u>03/07/</u>	2018	Date of Exam	110/03
Physical Exam Note: *Mandated Scre *Height 12 / id. /	ening/Test	to be comp	leted by provider	under	Connecticut State Lav		Blood Pressure	84,44
	Normal	Des	cribe Abnormal		Ortho	Normal	Describe A	bnormal
Neurologic					Neck			
HEENT					Shoulders			
*Gross Dental					Arms/Hands			
Lymphatic					Hips			
Heart					Knees			
Lungs					Feet/Ankles			
Abdomen Genitalia/ hernia Skin					*Postural DNo s abno	pinal ü rmality	I Spine abnormali I Mild I Marked I R	loderate
Screenings	<u> </u>				i			
	gerg Ex	c 76.	*Auditory Sci	reenin	g	History of	Lead level	Date
Туре:	Right	Lest	Type:	Righ	•		☐ No ☐ Yes	
With glasses	20/	20/	DAE	J-Pa	ss Pass	*НСТ/Н		
Without glasses	20/	20/	OAE	☐ Fa	il 🗆 Fail		(school entry only)	
☐ Referral made	207	201	☐ Referral m	nade		Other:	(school carry only)	
TB: High-risk group?	ZINO	☐ Yes	PPD date read:		Results:	L	reatment:	
*IMMUNIZATIO	· · · · · · · · · · · · · · · · · · ·				rooting,	*	- Cumon	
TUp to Date or C		odulo MI	CT HAVE IMAG	101177	TION DECODD AT	TA CHED		
*Chronic Disease Ass		icome. Mic	31 11/44 1/ 1/41/41	JINIZA	CHON RECORD AT	IACHED		
Asthma No	☐ Yes: □		nt		Moderate Persistent an to School	∷ □ Severe F	Persistent 🚨 Exerc	cise induced
		ide a copy o	Insects	Allerg		No □ Yes	(
Diabetes DNo	🗆 Yes: 🕻	Type I	⊔ Туре П	0	ther Chronic Diseas	e:		
Seizures 🗆 📉	☐ Yes, ty	pe:						
☐ This student has a dexplain: Daily Medications (sp. This student may: Д	pecify):	e fully in th	he school progra	m	iatric condition that m			
	l participate	in athletic	activities and con	npetitiv	e sports with the follo		<u>-</u>	
Is this the student's m					al examination, this street to discuss information	on in this repo	ort with the school ank J. Bush, MD, PC	
Mul 2 Signature of health care pro		DO/APRN/PA	· · · · · · · · · · · · · · · · · · ·		IAR 1 3 2023 Date Signed	M 8) ————	' Hillard Street anchester CT 06040 601646-3903 ed <i>Provider</i> Name and	Phone Number

4/27/2023 11:22 PM FROM: Staples TO: +18603260552 P.

HAR-3 REV. 7/2018

Part 3 — Oral Health Assessment/Screening Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

Signature of health care provider

DMD/DD\$/MD/DO/APRN/PA/RDH

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, M	iddle)		Birth Date	Date of Exam	
Williams Everett			03/07/2018		
School			Grade Male		Male
Home Address 436 Ripley Hill Road C Parent/Guardian Name (La			Home Phon	e	Cell Phone
Williams Christina	or I not readily		860-830-57		Contrione
Winding Officeria	- 18. F. S. d		1 000-000-01	100	<u> </u>
Dental Examination	Visual Screening	Normal		Referral Made:	
Completed by:	Completed by:	Yes		□ Yes	
☐ Dentist	☐ MD/DO ☐ APRN ☐ PA ☐ Dental Hygienist	Abnormal (D		G-No	
Risk Assessment		D	escribe Risk .	Factors	100 Maria 100 Ma
Low Moderate High	☐ Dental or orthodon ☐ Saliva ☐ Gingival condition ☐ Visible plaque ☐ Tooth demineraliza ☐ Other	ition	_	Carious lesion Restorations Pain Swelling Trauma Other	ıs
Recommendation(s) by hea	alth care provider:				
I give permission for releas use in meeting my child's l			etween the sch	ool nurse and health	care provider for confidential
Signature of Parent/Guar	rdian				Date
					lush, MD. PC
Mul & Els	wom, A-C	MAR	1 3 2023	27 Hillard Manchest (860)646-	er CT 06040

Date Signed

Printed/Stamped Provider Name and Phone Number

Student Name: Everett Williams	Birth Date: 03/07/2018	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 I		Dose 2		Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	05/14/18	*	07/13/18	*	09/10/18	* 06/10/19	03/11/22	
DT/Td									
Tdap	*							Required 7	th-12th grade
IPV/OPV	*	05/14/18	*	07/13/18	*	09/10/18	03/11/22		
MMR	*	03/08/19	*	03/11/22				Required K	-12th grade
Measles	*		*					Required K	-12th grade
Mumps	*		*						-12th grade
Rubella	*		*						-12th grade
HIB	*	05/14/18		07/13/18		06/10/19		PK and K (Students under age	
Нер А	*	03/08/19	*	09/16/19					ie grade requirement
Нер В	*	03/07/18	*	05/14/18	*	07/13/18	09/10/18	Required PK-12th grade	
Varicella	*	03/08/19	*	03/11/22					K-12th grade
PCV	*	05/14/18		07/13/18		09/10/18	06/10/19		ents under age 5)
Meningococcal	*								th-12th grade
HPV						v			
Flu	*	09/16/19		11/06/20		12/30/21	11/12/22	PK students 24-59 mon	ths old – given annually
Other Men B									
COVID Disease Hx			· · · · · · · · · · · · · · · · · · ·						
of above		(Specif	fy)			(Date)		(Confirmed	by)
Exempti	on:	Religious		Medical	: Perm	anent	Temporary	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: I dose on or after the lst birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: I 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: t 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: I 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.

Mad & Chesser, AA-C	MAR 1 3 2023	Frank J. Bush, MD, PC 27 Hillard Street Manchester CT 06040 (860)646-3903
Initial/Signature of health care provider MD / DO / APRN / PA	Date Signed	Printed/Stamped Provider Name and Phone Number

7/2023 11:22 PM FROM: Staples TO: +18603260552 P.



State of Connecticut Department of Education 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 pr	int					
Child's Name (Last, First, Middle)	^N1		Birth Date (_O[{	Male 🗆 F	emale	
Address (Street, Town and ZIP code)			UTIL			<u> </u>	·	
97 weir str	ut	, a lashonbun	1,0	, 0	6033			
Parent/Guardian Name (Last, First,	10		Home Phor	ne		Cell Phone	****	
Early Childhood Program (Name a	nd Phone Ni		Race/Ethni	•				
Annie ailnac		1 mg Carl	☐ America	n India	ın/Alaskan Na	tive 🔾 Hispanio	/Latino	
Primary Health Care Provider:	Marie	21000	Black, n	ot of H	lispanic origin	☐ Asian/Pa	cific Isla	ınder
Name of Dentist: Hayau		anily dotd	🗅 White, n	ot of I	Hispanic origin	Other		
Health Insurance Company/Num	ber* or M	edicaid/Number*						
Does your child have health insur Does your child have dental insur Does your child have HUSKY in	rance?	If you	r child does n	ot hav	e health insura	nce, call I-877-(T-HUS	KY
* If applicable			_					
		t I — To be completed						
Please answer these b							ation.	
Please circl	e Y if "ye:	s" or N if "no." Explain all "	yes" answers	in the	space provided	i below.		
Any health concerns	Y N	Frequent ear infections	Y	N	Asthma treatπ	ent	Y	¥
Allergies to food, bee stings, insects	YN	Any speech issues	Y	N	Seizure		Y	N
Allergies to medication	Y N	Aлу problems with teeth	Y	N	Diabetes		Y	N
Any other allergies	Y M	Has your child had a dental		M	Any heart prol		Y	N
Any daily/ongoing medications	Y M	examination in the last 6 me			Emergency ro		Y	N
Any problems with vision	Y M	Very high or low activity le		N/	Any major illr		Y	N-
Uses contacts or glasses	Y M	Weight concerns	Y	N-	Any operation		Y	N
Any hearing concerns	Y N	Problems breathing or coug	hing Y	N	Lead concerns		Y	N
		concern about your child's:	· · · · · · · · · · · · · · · · · · ·		Sleeping conc		Y	N
Physical development	Y N	5. Ability to communicate		Ne	High blood pr		Y	N
2. Movement from one place		6. Interaction with others	Y	×	Eating concern		Y	N
to another	Y N	7. Behavior	Y	N	Toileting conc		Y	N
3. Social development	Y N	8. Ability to understand	Y	M	Birth to 3 serv		Y	[A
4. Emotional development	Y N	9. Ability to use their hand	s Y	N	Preschool Spe	cial Education	Y	N
Explain all "yes" answers or provide	le any add	itional information:			·			
Have you talked with your child's pri	mary heal	th care provider about any of th	ie above concer	ns? Y	NNI	A-		
Please list any medications your chil						······································		
will need to take during program hou All medications taken in child care progra		sanavata Madiantian Andrani-	ne Form si 17		thorizon d			
An medications taken in critic care progra	ims require a	i separate ineacution Authorizatio	on rorm signea o	y an au	norizea prescribei	ana parent/guardia	i.	
I give my consent for my child's healt			1 . 1					
childhood provider or health/nurse consu- the information on this form for confid-			111			0412	(1)	}
child's health and educational needs in th			arent quardian			1 1 -	<u>, , , , , , , , , , , , , , , , , , , </u>	Date

ED 191 REV. 3/2015 C.G.S. Section 10-16q, 10-206, 19a.79(a), 19a-87b(c); P.H. Code Section 19a-79-5a(a)(2), 19a-87b-10b(2)

4/27/2023 11:22 PM FROM: Staples TO: +18603260552 FIG HEALTH PEDIATRICS LLC • 55 Nye Rd, Suite 105, GLASTONBURY CT 06033-2061 ATTIMU, Elorm (id #190, dob: 01/24/2018) Part 2 — Medical Evaluation Health Care Provider must complete and sign the medical evaluation and physical examination Student Name Elorm Attimu Birth Date01/24/2018 have reviewed the health history information provided in Part 1 of this form Date of Exam 03/15/2023 Physical Exam Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law Ht:45.25 in (114.93 RR:12 T:98.3 F° (36.83 C) cm; 87th %ile) Wt:60 lbs 3.2 oz BMI:20.7 (>99th %ile: BP: 102/58 (65th % / (27.31 kg; >99th Age and sex) 61st %) %ile) Pulse:84 bom Normal Describe Abnormal Ortho Normal Describe Abnormal Neurologic Neck HEENT **Shoulders** *Gross Dental Arms/Hands Lymphatic Hips Heart Knees Lungs Feet/Ankles Abdomen Postural 🖂 🗖 spinal abnormality 🖂 Spine abnormality: Genitalia/ hernia ☐ Mild ☐ Moderate Skin ☐ Marked ☐ Referral made Screenings Results None recorded Interpretations None recorded *Vision Screening **Auditory Screening** (See History of Lead level above + Photosomer Date Type: Right whi Left ≥ 5µg/dL □ No □ Yes Type: Right Left ☐ Pass ☐ Pass With glasses 20/ 20/ ☐ Fail □ Fail *HCT/HGB: (See above)* Without 20/ Speech (school entry only) alasses ☐ Referral made Referral made Other: TB: High-risk group? ☑No □ Yes PPD date read: Results: Treatment: *IMMUNIZATIONS Up to Date or A Catch-up Schedule: MUST HAVE IMMUNIZATION RECORD ATTACHED *Chronic Disease Assessment: →□ No □ Yes: □ Intermittent □ Mild Persistent □ Moderate Persistent □ Severe Persistent □ Exercise Induced **Asthma** If yes, please provide a copy of the Asthma Action Plan to School Anaphylaxis ☑ No ☐ Yes: ☐ Food ☐ Insects ☐ Latex ☐ Unknown source If yes, please provide a copy of the Emergency Allergy Plan to School Allerales No ☐ Yes: ☐ Type I ☐ Type II Diabetes 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. 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.

03/15/2023

Electronically Signed by: MANUEL A. ORTA COBO, MD

4/27/2023 11:22 PM FROM: Staples TO: +18603260552 P. 2

ATTIMU, Elorm (id #190, dob: 01/24/2018)

Signature of health care provider DMD/DDS/MD/DO/APRN/PA/RDH

Date Signed Printed/Stamped Provider Name and

Phone Number

TO: +18603260552 P

2. 25

FIG HEALTH PEDIATRICS LLC • 55 Nye Rd., Suite 105, GLASTONBURY CT 06033-2061

ATTIMU, Elorm (id #190, dob: 01/24/2018)

Part 3 — Oral Health Assessment/Screening Health Care Provider must complete and sign the oral health assessment.

HAR-3 REV. 7/2018

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, Fir	st, Middle)		Birth Date	Date of E	xam
Attimu Elorm			01/24/2018	03/15/20	
School	****		Grade	Sex:	The state of the s
Home Address				M M	-
97 Weir St	٠	•			
Glastonbury, CT 06033	}				
Parent/Guardian Name			Home Phone	Cell Phor	36
15 20			(860) 794-3790	(860) 794	
Dental Examination	Visual Screening	Normal		Referral Made:	I-04 90
Completed by:	Completed by:	Z Yes		Yes	,
☐ Dentist	ĿłMD/DO	☐ Abnorm	al (Describe)	□ No	
	☐ APRN				,
	□ PA			· .	
	☐ Dental Hyglenist			•	
	, , , , , , , , , , , , , , , , , , , ,				
	1				
Risk Assessment			Describe Risk Fa	<u> </u>	
☑ Low	☐ Dental or orthodontic	annliana	Describe Nisk Fa		
☐ Moderate	□ Saliva	appliance	•	☐ Carious lesion	18
☐ High	☐ Gingival condition			□ Restorations	
	1 -			☐ Pain	
	☐ Visible plaque			☐ Swelling	
	☐ Tooth demineralization			☐ Trauma	
	☐ Other			☐ Other	<u>, :</u>
					
Recommendation(s) by I	nealth care provider:		material de la companya de la compa		
		• *************************************			
give permission for rele	ase and exchange of inform	nation on this fo	rm between the schoo	nurse and health care p	provider for confidential
use in meeting my child's	s health and educational ne	eds in school.			
Signature of Parent/Gua					
olgilature di Farenivotia	rolan		•		Date
Electronically Signed by:	MANUEL A, ORTA COBO	MD	03/15/202		
	WHATCHE AS ON THE CORD	1 JAIL	V3/13/202	3 :	
	•				
•			•		
			•		
				·	
	•	•			

Initial/Signature of health care provider MD / DO / APRN / PA

TO: +18603260552

P. 26

Printed/Stamped *Provider* Name and Phone Number

Hep A, ped/arcid, 2 dose Hep A, ped/adol, 2 dose	10/05/21 3yámo 0	Temi et dindere dan 11 - 12 - 12 - 14 5 mL Internuscular	List is to			exoSmithKline	and definitely defended by any and a service of the	
Hepatitis B Hep B. adolescent or pediation		Territoria presidente	e de la composition della comp				ingerec Garaga Nepallis A	DBUE2TO Manuel Orta
Hep B, adolescent or pediatric Hep B, adolescent or padiatric	12/28/21 3y11mo 0 39/28/21 3y11mo 0			77)		axoSmithKilne	12/22/25	¢⊈ cobo. MD
Influenza nfluenza, Injectable, quadrivalent, preservative free	01/09/22 3y11m6 0	5 mL Intramuscular	Deltoid, Rìght	49261042188 UT	7376KA S	ınoli Pasteur	06/30/22 Inactivated Influenza 08/06/2021	01/09/22 Manuel Orta cobe, MD
Measles, Mumps, Rube MMR				overale provi				19/13/22 Manuel Orta ≘coco, MD
Pneumococcal Conjugate PCV	02/24/20 2y1mo							
meumosoccal confugate PGA/ IS / Police								
PV PV	05/06/19 1y3mo					ir erston Votersi		
otaP-Hib-iPV Variceila varicella	03/30/18 2m6dq B3/15P8/593 1 0						10 10 Varicella 10 10 24 Varicella 10 10 10 10 10 10 10 10 10 10 10 10 10 1	109/15/23 Manuel Orta cobo MD
Some vaccines listed in Do the patient's chart man electronically Signed by: W	nually as needed.		dded to t		art. Plea			
	Jack Committee of the C			· ·				

Date Signed

4/27/2023 11:22 PM FROM: Staples TO: +18603260552 FIG HEALTH PEDIATRICS LLC . 55 Nye Rd, Suite 105, GLASTONBURY CT 06033-2061 ATTIMU, Elorm (id #190, dob: 01/24/2018) Student Name: Elorm Attimu Birth Date: 01/24/2018 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 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 Required K-12th grade Rubella Required K-12th grade HIB PK and K (Students under age 5) Hep A See below for specific grade requirement Нер В Required PK-12th grade Varicella Required K-12th grade PCV PK and K (Students under age 5) Meningococcal Required 7th-12th grade HPV Plu PK students 24-59 months old - given annually Other Disease Hx of (Specify) (Date) (Confirmed by) above 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 **HEPATITIS A VACCINE 2 DOSE GRADES 7 THROUGH 12** REQUIREMENT PHASE-IN DATES *DTaP: At least 4 doses, with the final dose on or *Tdap/Td: 1 dose of Tdap required for students. August 1, 2017: Pre-K through 5th grade after the 4th birthday; students who start the who completed their primary DTaP series; for August 1, 2018: Pre-K through 6th grade series at age 7 or older only need a total of 3 August 1, 2019: Pre-K through 7th grade
August 1, 2020: Pre-K through 8th grade students who start the series at age 7 or older a doses of tetanus-diphtheria containing vaccine. total of 3 doses of tetanus-diphtheria containing ·Polio: At least 3 doses, with the final dose on or vaccines are required, one of which must be Tdap. August 1, 2021: Pre-K through 9th grade · August 1, 2022: Pre-K through 10th grade after the 4th birthday. ·Polio: At least 3 doses, with the final dose on or •MMR: 2 doses at least 28 days apart, with the 1st after the 4th birthday. August 1, 2023: Pre-K through 11th grade dose on or after the 1st birthday. -MMR: 2 doses at least 28 days apart; with the 1st - August 1, 2024; Pre-K through 12th grade ·Hib: 1 dose on or after the 1st birthday (children 5 dose on or after the 1st birthday. years and older do not need proof of Meningococcal: 1 dose ** Verification of disease: Confirmation in vaccination). •Hep B: 3 doses, with the final dose on or after 24 writing by an MD, PA, or APRN that the child has Pneumococcal: 1 dose on or after the 1st weeks of age. a previous history of disease, based on family or birthday (children 5 years and older do not need *Varicella: 2 doses, with the 1st dose on or after medical history. proof of vaccination). the 1st birthday or verification of disease. ·Hep A: 2 doses given six months apart, with the *Hep A: 2 doses given six months apart, with the Note: The Commissioner of Public Health may 1st dose on or after the 1st birthday. See 1st dose on or after the 1st birthday. See issue a temporary waiver to the schedule for "HEPATITIS A VACCINE 2 DOSE "HEPATITIS A VACCINE 2 DOSE active immunization for any vaccine if the REQUIREMENT PHASE-IN DATES" column at REQUIREMENT PHASE-IN DATES" column at National Centers for Disease Control and the right for more specific information on grade. the right for more specific information on grade Prevention recognizes a nationwide shortage of level and year required. level and year required. supply for such vaccine. 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.** **Reviewed Vaccines** Date Age Amt. Vaccine Type Route Site Mfr. VIS VIS Vaccinator Lot# Exp. Given Date Diphtheria, Tetanus, Pertussis 07/22/40 14 DTaP DTaP 03/12/19 1y1mo DTOP 08/27/18 Fm3 M DTaP-Hib-IPV 08/30/18 2m6do Haemophilus Influenzae Type By Hib 02/24/2012/1995 Hib 07/30/18 6m6do Hib

03/30/18 2m6do

DTaP-Hib-IPV

Hepatitis A