CHILD ENROLLMENT FORM

Date of Application: 5-1-18 **Date of Enrollment:** 5-7-18 **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 Ripley Hill Rd City: Coventry Zip Code 06238

Mother's Name: Christina Williams Address: 436 Ripley Hill Rd
City: Coventry Zip Code: 06238
Home Telephone #: ( ) Cell #: (860) 830-5733
Emergency Contact # (860) 830-5733 e-mail Address: ncuprincess@gmail.com

Mother's Employer: RTX Work #: (860) 830-5733
Mother's Employer Address: 400 main st City E. Hartford Zip Code 06

Father's Name: Ryan Willems Address: 436 Ripley Hill Rd
City: Coventry Zip Code: 06238
Home Telephone #: ( ) Cell #: (860) 916-2833
Emergency Contact # (860) 916-2833 e-mail Address: Ryan.T.Williams@hotmail.com

Father's Employer: RTX Work #: (860) 565-4991
Father's Employer Address: 400 main st City: E. Hartford Zip Code 06

My Child's Weekly Child Care Schedule:

Day(s)	Hours
Monday 8-5 ✓	8 am - 5 pm
Tuesday	
Wednesday 8-5 ✓	8 am - 5 pm
Thursday 8-5 ✓	8 am - 5 pm
Friday	
Saturday	
Sunday	

Signature of Parent or Guardian: _____ **Date:** 4/17/23

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 Ripley Hill Rd City: Coventry Zip Code 06238

Mother's Name: Christina Williams Address: 436 Ripley Hill Rd
City: Coventry Zip Code: 06238
Home Telephone #: ( ) Cell #: (860) 830-5733
Emergency Contact # (860) 830-5733 e-mail Address: aeoprincess@gmail.com

Mother's Employer: RTX Work #: (860) 830-5733
Mother's Employer Address: 400 main st City: E. Hartford Zip Code 06

Father's Name: Ryan Williams Address: 436 Ripley Hill Rd
City: Coventry Zip Code: 06238
Home Telephone #: ( ) Cell #: (860) 916-2833
Emergency Contact # (860) 916-2833 e-mail Address: Ryan.T.Williams@hotmail.com

Father's Employer: RTX Work #: (860) 565-4991
Father's Employer Address: 40 Main St City: E. Hartford Zip Code 06

My Child's Weekly Child Care Schedule:

Day(s)	Hours
Monday ✓	8 am - 5 pm
Tuesday	
Wednesday ✓	8 am - 5 pm
Thursday ✓	8 am - 5 pm
Friday	
Saturday	
Sunday	

Signature of Parent or Guardian: _____ **Date:** 4/17/23

CHILD ENROLLMENT FORM

Date of Application: ~~1-17-23~~ 1-17-23 **Date of Enrollment:** 1-17-23 **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: 97 weir street, Glastonbury, CT, Zip Code 06033

Mother's Name: Nana Attimu Address: same.
City: _____ Zip Code: _____
Home Telephone #: (860) 794 3790 Cell #: (____) _____
Emergency Contact # (____) _____ e-mail Address: _____

Mother's Employer: ST. Francis Hospital Work #: (____) _____
Mother's Employer Address: 114 woodland St City: Hartford Zip Code 06119

Father's Name: Sodzi Attimu Address: same.
City: _____ Zip Code: _____
Home Telephone #: (203 615 1394 Cell #: (____) _____
Emergency Contact # (860) 328 6319 e-mail Address: _____

Father's Employer: Mass Mutual Work #: (____) _____
Father's Employer Address: 1277 main St, City: Springfield Zip Code 01103

My Child's Weekly Child Care Schedule:

Day(s)	Hours
Monday ✓	8-5
Tuesday ✓	✓
Wednesday ✓	✓
Thursday ✓	✓
Friday ✓	✓
Saturday _____	✓
Sunday _____	_____

Signature of Parent or Guardian: _____ **Date:** 4/25/23

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

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.

Please print

Child's Name (Last, First, Middle): **Attimu Akorfa**	Birth Date: **08/11/2019**	Gender: F
Address (Street, Town and ZIP code): **97 Weir St, Glastonbury CT 06033-2709**		
Parent/Guardian Name:(Last, First, Middle):	Home Phone: **(860) 794-3790**	Cell Phone: **(860) 794-3790**
Early Childhood Program (Name and Phone Number) :	Race/Ethnicity **Black or African American** **Not Hispanic or Latino**	
Primary Health Care Provider: **None recorded** Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*: **Cigna U4971684505**		
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 your child does not have health insurance, call **1-877-CT-HUSKY**	

* 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	Y N	Frequent ear infections	Y N	Asthma treatment	Y N
Allergies to food, bee stings, insects	Y N	Any speech issues	Y N	Seizure	Y N
Allergies to medication	Y N	Any problems with teeth	Y N	Diabetes	Y N
Any other allergies	Y N	Has your child had a dental examination in the last 6 months	Y N	Any heart problems	Y N
Any daily/ongoing medications	Y N			Emergency room visits	Y N
Any problems with vision	Y N	Very high or low activity level	Y N	Any major illness or injury	Y N
Uses contacts or glasses	Y N	Weight concerns	Y N	Any operations/surgeries	Y N
Any hearing concerns	Y N	Problems breathing or coughing	Y N	Lead concerns/poisoning	Y N
Developmental - Any concern about your child's:				Sleeping concerns	Y N
1. Physical development	Y N	5. Ability to communicate needs	Y N	High blood pressure	Y N
2. Movement from one place to another	Y N	6. Interaction with others	Y N	Eating concerns	Y N
		7. Behavior	Y N	Toileting concerns	Y N
3. Social development	Y N	8. Ability to understand	Y N	Birth to 3 services	Y N
4. Emotional development	Y N	9. Ability to use their hands	Y N	Preschool Special Education	Y N

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 N/A

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 [signature] Date 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.

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 print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	☐ Male ☒ Female
Attimu, AKorfa	08/11/2019	
Address (Street, Town and ZIP code) 97 Weir Street, Glastonbury, CT, 06033		
Parent/Guardian Name (Last, First, Middle) Hana [illegible]	Home Phone	Cell Phone 860 794 379
Early Childhood Program (Name and Phone Number) Annie Gilbreck daycare.	Race/Ethnicity: ☐ American Indian/Alaskan Native ☐ Hispanic/Latino ☒ Black, not of Hispanic origin ☐ Asian/Pacific Islander ☐ White, not of Hispanic origin ☐ Other	
Primary Health Care Provider: Manual Ortiz Name of Dentist: FIG Health Pad.		
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 your child does not have health insurance, call **1-877-CT-HUSKY**

* 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	Y	~~N~~	Frequent ear infections	Y	~~N~~	Asthma treatment	Y	~~N~~
Allergies to food, bee stings, insects	Y	~~N~~	Any speech issues	Y	~~N~~	Seizure	Y	~~N~~
Allergies to medication	Y	~~N~~	Any problems with teeth	Y	~~N~~	Diabetes	Y	~~N~~
Any other allergies	Y	~~N~~	Has your child had a dental			Any heart problems	Y	~~N~~
Any daily/ongoing medications	Y	~~N~~	examination in the last 6 months	Y	N	Emergency room visits	Y	~~N~~
Any problems with vision	Y	~~N~~	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	~~N~~	Weight concerns	Y	N	Any operations/surgeries	Y	~~N~~
Any hearing concerns	Y	~~N~~	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	~~N~~
Developmental — Any concern about your child's:						Sleeping concerns	Y	~~N~~
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place to another	Y	N	6. Interaction with others	Y	N	Eating concerns	Y	N
			7. Behavior	Y	~~N~~	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	~~N~~	Preschool Special Education	Y	~~N~~

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 N/A

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: 4/25/23

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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** Birth Date: **08/11/2019** Date of Exam: **10/13/2022**

☐ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

Vitals

Ht: 38.9 in (98.81 cm; 82nd %ile) 10/13/2022 04:04 pm	**RR:** 12 10/13/2022 04:04 pm	**T:** 98.3 F° (36.83 C) 10/13/2022 04:04 pm
Wt: 37 lbs 6.4 oz (16.96 kg; 91st %ile) 10/13/2022 04:03 pm	**BMI:** 17.4 (89th %ile: Age and sex) 10/13/2022 04:04 pm	**Pulse:** 98 bpm 10/13/2022 04:05 pm

Screenings

***Vision Screening**
☑ EPSDT Subjective Screen Completed (Birth to 3 yrs)
☐ EPSDT Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

☐ Unable to assess
☐ Referral made to:

***Hearing Screening**
☐ EPSDT Subjective Screen Completed (Birth to 4 yrs)
☐ EPSDT Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
	☐ Pass ☐ Fail	☐ Pass ☐ Fail

☐ Unable to assess
☐ Referral made to:

***Anemia:** at 9 to 12 months and 2 years

***Hgb/Hct:** *** Date**

***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months

History of Lead level ≥ 5µg/dL ☑ No ☐ Yes

***Result/Level:** *** Date**

***TB:** High-risk group? ☑ No ☐ Yes
Test done: ☐ No ☐ Yes Date:
Results:
Treatment:

***Dental Concerns:** ☑ No ☐ Yes
☐ Referral made to:
Has this child received dental care in the last 6 months? ☐ No ☑ Yes

Other:

***Developmental Assessment:** (Birth – 5 years) ☐ No ☑ Yes **Type:** In person

Results: WNL

***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 an ***Asthma Action Plan***
☐ Rescue medication required in child care setting: ☐ No ☐ Yes:

Allergies ☑ No ☐ Yes
Epi Pen required: ☐ No ☐ Yes
History/risk of Anaphylaxis: ☐ No ☐ Yes: ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Unknown source
If yes, please provide a copy of the ***Emergency Allergy Plan***

Diabetes ☑ No ☐ Yes: ☐ Type I ☐ Type II **Other Chronic Disease:**

Seizures ☑ No ☐ Yes: Type:

☐ This child has the following problems which may adversely affect his or her educational experience:
☐ Vision ☐ Auditory ☐ Speech/Language ☐ Physical ☐ Emotional/Social ☐ Behavior
☐ This child has a developmental delay/disability that may require intervention at the program.
☐ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:*

☐ No ☐ Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.
☐ No ☐ Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.
☐ No ☑ Yes This child may fully participate in the program.
☐ No ☑ Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

☐ No ☑ Yes Is this the child's medical home? NO ☐ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

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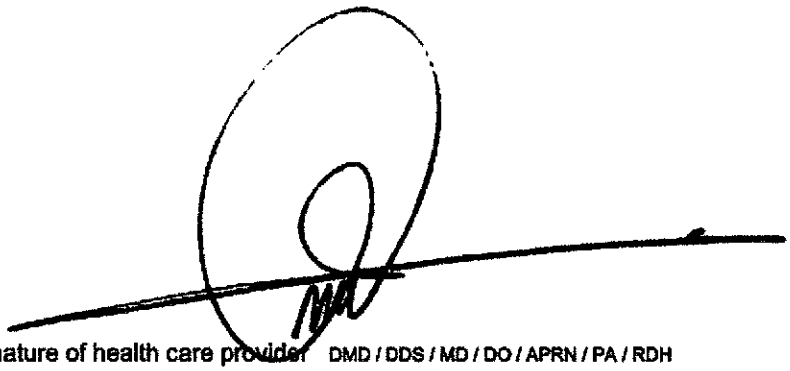
ATTIMU, Akorfa (id #207, dob: 08/11/2019)



Signature of health care provider DMD / DDS / MD / DO / APRN / PA / RDH	Date Signed	Printed/Stamped ***Provider*** Name and Phone Number

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

HAR-3 REV. 7/2018

Health Care Provider must complete and sign the oral health assessment.

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, First, Middle)	Birth Date	Date of Exam
Attimu Akorfa	**08/11/2019**	**10/13/2022**
School	Grade	Sex: **F**

Home Address
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 Completed by:	**Visual Screening** Completed by:	**Normal**	**Referral Made:**
☐ Dentist	☑ MD/DO ☐ APRN ☐ PA ☐ Dental Hygienist	☑ Yes ☐ Abnormal (Describe) _____	☐ Yes ☑ No

Risk Assessment	**Describe Risk Factors**	
☑ Low ☐ Moderate ☐ High	☐ Dental or orthodontic appliance ☐ Saliva ☐ Gingival condition ☐ Visible plaque ☐ Tooth demineralization ☐ Other _____	☐ Carious lesions ☐ Restorations ☐ Pain ☐ Swelling ☐ Trauma ☐ Other

Recommendation(s) by health care provider: _____

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 Date

Electronically Signed by: MANUEL A. ORTA COBO, MD **04/27/2023**

ProHealth Physicians

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

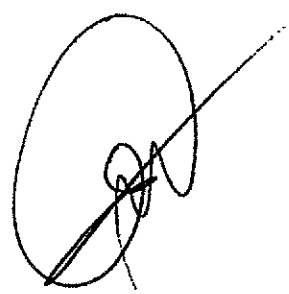
Allscripts

Patient:Attinn, Akorfa
EMRN: 9229930
OMRN: 9229930

Age: 1 year
DOB: 08/11/2019
Home: (860) 794-3790

Immunization Series Record

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	
Polio		2	12-May-2020 (9 mo.)	Admin	
Polio		3	16-Jul-2020 (11 mo.)	Admin	



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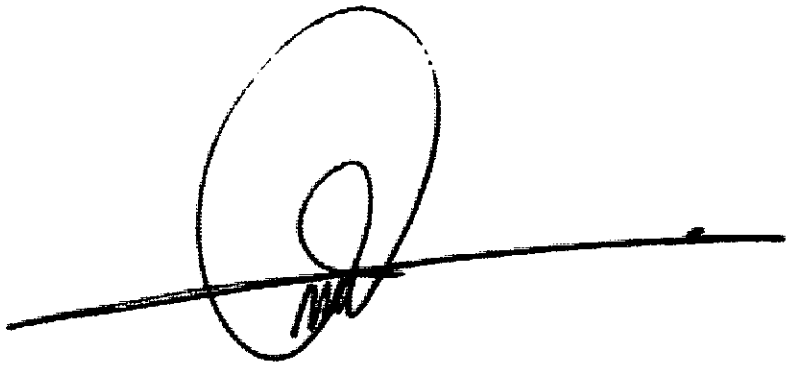
ATTIMU, Akorfa (id #207, dob: 08/11/2019)

Electronically Signed by: MANUEL A. ORTA COBO, MD

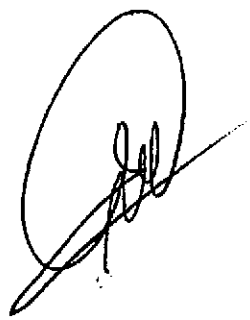


Initial/Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped *Provider* Name and Phone Number

04/27/2023

Reviewed Vaccines

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



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

Child's Name: Akorfa Attimu **Birth Date:** 08/11/2019 REV. 10/2018

Immunization Record

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

Vaccine (Month/Day/Year) _____

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Flu						
Other						

Disease history for varicella (chickenpox) _____ (Date) (Confirmed by)

Exemption: **Religious** _____ **Medical: Permanent** _____ † **Temporary** _____ **Date** _____

† Recertify Date _____ † Recertify Date _____ † Recertify Date _____

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

Vaccines	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 birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
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 given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	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 birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	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
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
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
6. 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

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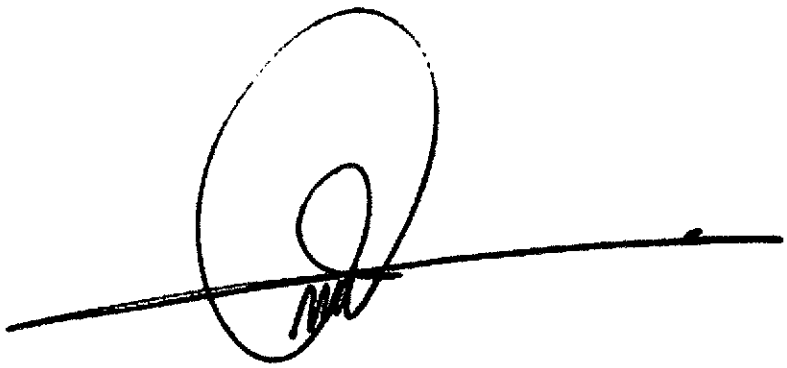
ATTIMU, Akorfa (id #207, dob: 08/11/2019)

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 childhood providers ne[ed] 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 [co]mpletes 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
Williams, Gavin Scott	06/06/2019	

Address (Street, Town and ZIP code)
436 Ripley Hill Road Coventry, CT 06238

Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
Williams, Christina	860-830-5733	860-830-5733

Early Childhood Program (Name and Phone Number) 860 Ann Gilnack Daycare 6330416

Primary Health Care Provider: Frank Bush MD

Name of Dentist: Smiles for the Future

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

Health Insurance Company/Number* or Medicaid/Number*
Blue Cross - Blue Care $00.00 UQK197W10857

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

* 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	Y	N	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental			Any heart problems	Y	N
Any daily/ongoing medications	Y	N	examination in the last 6 months	(Y)	N	Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place to another	Y	N	6. Interaction with others	Y	N	Eating concerns	Y	N
			7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

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.

Christina Williams 8/19/22

Signature of Parent/Guardian Date

ED 191 REV 3/2016

Part II — Medical Evaluation

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

Child's Name Gavin Williams Birth Date 06/06/2019 (mm/dd/yyyy) Date of Exam 8/19/22 (mm/dd/yyyy)

☑ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

*HT 39½ in/cm 83 % *Weight 50 lbs. oz / 82 g BMI 16/62 % *HC cm % (Birth – 24 months) *Blood Pressure 90 / 60 (Annually at 3 – 5 years)

Screenings

***Vision Screening**
☐ EPSDT Subjective Screen Completed (Birth to 3 yrs)
☐ EPSDT Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type: See 5 eye	Right	Left
With glasses MD	20/	20/
Without glasses	20/	20/

☐ Unable to assess
☐ Referral made to:

***Hearing Screening**
☑ EPSDT Subjective Screen Completed (Birth to 4 yrs)
☑ EPSDT Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type: At Birth	Right	Left
	☑ Pass	☐ Pass
	☐ Fail	☐ Fail

☐ Unable to assess
☐ Referral made to

***Anemia:** at 9 to 12 months and 2 years

(Hgb/Hct: 11.1 *Date 8/19/22

***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months

History of Lead level ≥ 5µg/dL ☑ No ☐ Yes

***TB:** High-risk group? ☑ No ☐
Yes Test done: ☐ No ☐ Yes Date
Results:
Treatment:

***Dental Concerns** ☑ No ☐ Yes
☐ Referral made to:
Has this child received dental care in the last 6 months? ☐ No ☑ Yes

*Result/Level: 3.5 ug/dL *Date 6/23/2022
Other:

***Developmental Assessment:** (Birth – 5 years) ☐ No ☑ Yes Type: PEDS

Results: Passed

***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 an Asthma Action Plan
☐ Rescue medication required in child care setting: ☐ No ☐ Yes

Allergies ☑ No ☐ Yes:
Epi Pen required: ☐ No ☐ Yes
History/risk of Anaphylaxis: ☐ No ☐ Yes: ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Unknown source
If yes, please provide a copy of the Emergency Allergy Plan

Diabetes ☑ No ☐ Yes: ☐ Type I ☐ Type II **Other Chronic Disease:**
Seizures ☑ No ☐ Yes: Type:

☐ This child has the following problems which may adversely affect his or her educational experience:
☐ Vision ☐ Auditory ☐ Speech/Language ☐ Physical ☐ Emotional/Social ☐ Behavior
☐ This child has a developmental delay/disability that may require intervention at the program.
☐ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:*

☑ No ☐ Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.
☐ No ☑ Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.
☐ No ☑ Yes This child may fully participate in the program.
☑ No ☐ Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

☐ No ☑ Yes Is this the child's medical home? ☐ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

R Pemberton MD 8-19-22
Signature of health care provider MD / DO / APRN-NPA Date Signed

Frank J. Bush, MD, PC
27 Hilliard Street
Manchester, CT 06040
(860)646-3803
Printed/Stamped *Provider* Name and Phone Number

Child's Name: Gavin Williams Birth Date: 06/06/2019 REV. 1/2015

Immunization Record

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

Vaccine (Month/Day/Year)

	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		
IPV/OPV	08/08/19	10/09/19	12/11/19			
MMR	06/23/20					
Measles						
Mumps						
Rubella						
Hib	08/08/19	10/09/19	09/10/20			
Hepatitis A	06/23/20	02/19/21				
Hepatitis B	06/06/19	08/08/19	10/09/19	12/11/19		
Varicella	06/23/20					
PCV* vaccine	08/08/19	10/09/19	12/11/19	09/10/20		
Rotavirus	08/08/19	10/09/19	12/11/19			
MCV**						
Influenza	12/11/19	03/10/20	09/10/20	10/22/21		
Tdap/Td						

*Pneumococcal conjugate vaccine **Meningococcal conjugate vaccine

Disease history for varicella (chickenpox) _____
(Date) (Confirmed by)

Exemption: Religious _____ Medical: Permanent _____ †Temporary _____ Date _____
†Recertify Date _____ †Recertify Date _____ †Recertify Date _____

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

Vaccines	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	4 doses	3 doses	4 doses	4 doses	4 doses[3]
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 birthday[4]	1 dose after 1st birthday[4]	1 dose after 1st birthday[4]	1 dose after 1st birthday[4]	1 dose after 1st birthday[4]
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 given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1]	1 dose after 1st birthday or prior history of disease[1]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	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 birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	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
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (Pedvax-HIB) or 3 doses of HBOC (ActHib or Pentacel)
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
6. 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

Frank J. Bush MD PC
27 Hilliard Street
Manchester CT 06040
(860)648-3903

R. Pemberton MD 8-19-22

Initial/Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped *Provider* Name and Phone Number

State of Connecticut Department of Education
Health Assessment Record

CSDE

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)	Birth Date	☒ Male ☐ Female
Williams, Everett	03/07/2018	

Address (Street, Town and ZIP code)
436 Ripley Hill Road Coventry, CT 06238

Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
Williams, Christina	860-830-5733	860-830-5733

School/Grade —

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

Primary Care Provider
Ann Gilnack Daycare

Health Insurance Company/Number* or Medicaid/Number*
Blue Cross - Blue Care $00.00 UQK601M63347

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.

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 — 3/13/2023 Date

HAR-3 REV. 7/2018

To be maintained in the student's Cumulative School Health Record

HAR-3 REV. 7/2018

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name Everett Williams Birth Date 03/07/2018 Date of Exam 3/13/23

☑ 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** 42 1/4 in. / 36% ***Weight** 40 lbs. / 45% **BMI** 15 / 61% **Pulse** ____ ***Blood Pressure** 84/44

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic	—		Neck	—	
HEENT	—		Shoulders	—	
*Gross Dental	—		Arms/Hands	—	
Lymphatic	—		Hips	—	
Heart	—		Knees	—	
Lungs	—		Feet/Ankles	—	
Abdomen	—				
Genitalia/ hernia	—				
Skin	—				

***Postural** ☑ No spinal abnormality ☐ Spine abnormality: ☐ Mild ☐ Moderate ☐ Marked ☐ Referral made

Screenings

***Vision Screening** 2019 cc

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

☐ Referral made

***Auditory Screening**

Type: OAE Right ☐ Pass ☐ Fail Left ☐ Pass ☐ Fail

☐ Referral made

	Date
History of Lead level ≥ 5µg/dL ☐ No ☐ Yes	
***HCT/HGB:**	
***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 ☑ No ☐ Yes: ☐ Food ☐ Insects ☐ Latex ☐ Unknown source

Allergies *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
Mark S. Ebersen, PA-C	MAR 13 2023	Frank J. Bush, MD. PC 27 Hillard Street Manchester CT 06040 (860)646-3903

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):

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, Middle)	Birth Date	Date of Exam
Williams Everett	03/07/2018	
School	Grade	Male
Home Address: 436 Ripley Hill Road Coventry CT 06238		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
Williams Christina	860-830-5733	

Dental Examination	**Visual Screening**	**Normal**	**Referral Made:**
Completed by: ☐ Dentist	Completed by: ☐ MD/DO ☐ APRN ☑ PA ☐ Dental Hygienist	☑ Yes ☐ Abnormal (Describe)	☐ Yes ☑ No

Risk Assessment	**Describe Risk Factors**	
☑ Low ☐ Moderate ☐ High	☐ Dental or orthodontic appliance ☐ Saliva ☐ Gingival condition ☐ Visible plaque ☐ Tooth demineralization ☐ Other _____	☐ Carious lesions ☐ Restorations ☐ Pain ☐ Swelling ☐ Trauma ☐ Other _____

Recommendation(s) by health care provider: _____

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 — Date

Mark S. Elsesser, PA-C — MAR 13 2023

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

Frank J. Bush, MD. PC
27 Hilliard Street
Manchester CT 06040
(860)646-3903

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 1	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 7th-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	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	* 05/14/18	07/13/18	06/10/19		PK and K (Students under age 5)	
Hep A	* 03/08/19	* 09/16/19			See below for specific grade requirement	
Hep B	* 03/07/18	* 05/14/18	* 07/13/18	09/10/18	Required PK-12th grade	
Varicella	* 03/08/19	* 03/11/22			Required K-12th grade	
PCV	* 05/14/18	07/13/18	09/10/18	06/10/19	PK and K (Students under age 5)	
Meningococcal	*				Required 7th-12th grade	
HPV						
Flu	* 09/16/19	11/06/20	12/30/21	11/12/22	PK students 24-59 months old – given annually	
Other Men B						
COVID						

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.

Mark S. Eberson, PA-C MAR 13 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

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 print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	☒ Male ☐ Female
Attime, Elorm	01/24/2018	
Address (Street, Town and ZIP code)		
97 weir Street, Glastonbury, CT, 06033		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
Attimu Mana B		
Early Childhood Program (Name and Phone Number)	Race/Ethnicity	
Annie Gilnack daycare	☐ American Indian/Alaskan Native	☐ Hispanic/Latino
Primary Health Care Provider: Manuel Lorja	☒ Black, not of Hispanic origin	☐ Asian/Pacific Islander
Name of Dentist: Mayan Family dental	☐ White, not of Hispanic origin	☐ Other
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 your child does not have health insurance, call 1-877-CT-HUSKY

* 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	Y	N	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental			Any heart problems	Y	N
Any daily/ongoing medications	Y	N	examination in the last 6 months	Y	N	Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place to another	Y	N	6. Interaction with others	Y	N	Eating concerns	Y	N
			7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

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 N/A

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: 04/25/23

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

Part 2 — Medical Evaluation

HAR-3 REV. 7/201

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name **Elorm Attimu** Birth Date **01/24/2018** Date of Exam **03/15/2023**

☑ 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

Ht: 45.25 in (114.93 cm; 87th %ile) **RR:** 12 **T:** 98.3 F° (36.83 C)

Wt: 60 lbs 3.2 oz (27.31 kg; >99th %ile) **BMI:** 20.7 (>99th %ile: Age and sex) **BP:** 102/58 (65th % / 61st %)

Pulse: 84 bpm

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic	✓		Neck	✓	
HEENT	✓		Shoulders	✓	
*Gross Dental	✓		Arms/Hands	✓	
Lymphatic	✓		Hips	✓	
Heart	✓		Knees	✓	
Lungs	✓		Feet/Ankles	✓	
Abdomen	✓				
Genitalia/ hernia	✓				
Skin	✓				

***Postural** ☑ No spinal abnormality ☐ Spine abnormality: ☐ Mild ☐ Moderate ☐ Marked ☐ Referral made

Screenings

Results

None recorded

Interpretations

None recorded

Vision Screening (See above) Photoscreener = WNL			***Auditory Screening**			History of Lead level ≥ 5µg/dL ☐ No ☐ Yes	Date
Type:	Right	Left	Type:	Right	Left		
With glasses	20/	20/		☐ Pass	☐ Pass		
Without glasses	20/	20/		☐ Fail	☐ Fail	***HCT/HGB: (See above)***	
☐ Referral made			☐ Referral made			***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 ☑ No ☐ Yes: ☐ Food ☐ Insects ☐ Latex ☐ Unknown source

Allergies *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.

Electronically Signed by: MANUEL A. ORTA COBO, MD **03/15/2023**

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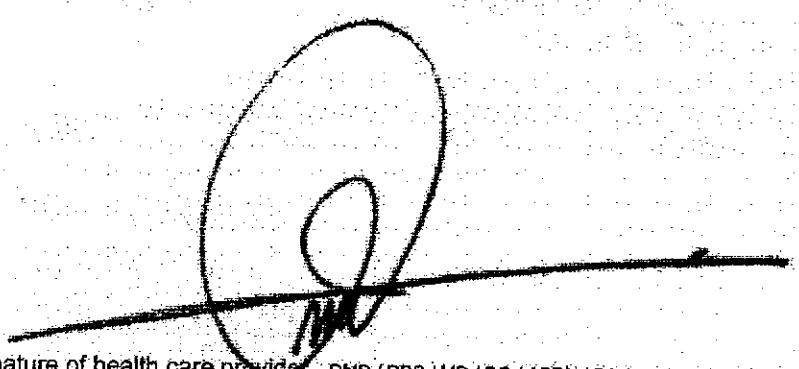
ATTIMU, Elorm (id #190, dob: 01/24/2018)



Signature of health care provider DMD / DDS / MD / DO / APRN / PA / RDH | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number

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

Part 3 — Oral Health Assessment/Screening

HAR-3 REV. 7/2018

Health Care Provider must complete and sign the oral health assessment.

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, First, Middle)	Birth Date	Date of Exam
Attimu Elorm	**01/24/2018**	**03/15/2023**
School	Grade	Sex: **M**

Home Address
97 Weir St
Glastonbury, CT 06033

Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
	(860) 794-3790	**(860) 794-3790**

Dental Examination Completed by:	**Visual Screening** Completed by:	**Normal**	**Referral Made:**
☐ Dentist	☑ MD/DO ☐ APRN ☐ PA ☐ Dental Hygienist	☑ Yes ☐ Abnormal (Describe) _____	☐ Yes ☑ No

Risk Assessment	**Describe Risk Factors**	
☑ Low ☐ Moderate ☐ High	☐ Dental or orthodontic appliance ☐ Saliva ☐ Gingival condition ☐ Visible plaque ☐ Tooth demineralization ☐ Other _____	☐ Carious lesions ☐ Restorations ☐ Pain ☐ Swelling ☐ Trauma ☐ Other

Recommendation(s) by health care provider: _____

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 _____ Date

Electronically Signed by: MANUEL A. ORTA COBO, MD **03/15/2023**

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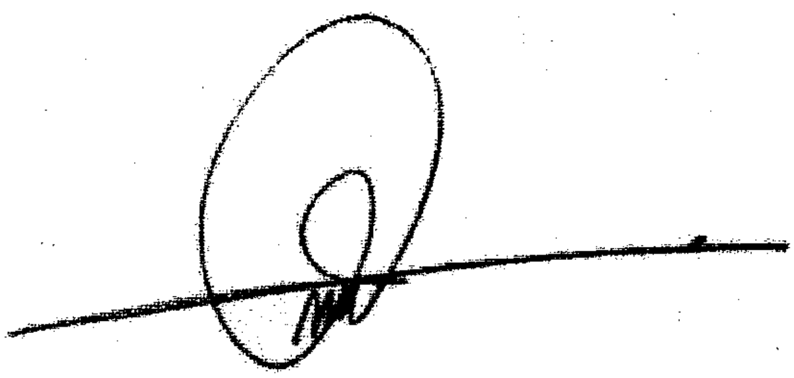
ATTIMU, Elorm (id #190, dob: 01/24/2018)

Hep A, ped/adol, 2 dose	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Hepatitis A 10/15/2021	08/02/22	Manuel Orta cobo, MD
Hep A, ped/adol, 2 dose	10/05/21	3y8mo	0.5 mL	Intramuscular			7HJ74	GlaxoSmithKline	08/21/22			
Hepatitis B												
Hep B, adolescent or pediatric	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Hepatitis B 10/15/2021	08/02/22	Manuel Orta cobo, MD
Hep B, adolescent or pediatric	12/28/21	3y11mo	0.5 mL	Intramuscular			77X47	GlaxoSmithKline	12/22/23			
Hep B, adolescent or pediatric	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	[illegible]			
Influenza												
influenza, injectable, quadrivalent, preservative free	01/09/22	3y11mo	0.5 mL	Intramuscular	Deltoid, Right	49281042188	UT7376KA	Sanofi Pasteur	06/30/22	Inactivated Influenza 08/06/2021	01/09/22	Manuel Orta cobo, MD
Measles, Mumps, Rubella												
MMR	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	MMR 08/06/2021	10/13/22	Manuel Orta cobo, MD
Pneumococcal												
pneumococcal conjugate PCV 13	02/24/20	2y1mo										
pneumococcal conjugate PCV 13	[illegible]	[illegible]										
Polio												
IPV	05/06/19	1y3mo										
IPV	[illegible]	[illegible]										
DTaP-Hib-IPV	03/30/18	2m6do										
Varicella												
varicella	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Varicella 08/06/2021	03/15/23	Manuel Orta cobo, MD

Some vaccines listed in Document: #11275 could not be added to this patient's chart. Please review this document and add these vaccines to the patient's chart manually as needed.

Electronically Signed by: MANUEL A. ORTA COBO, MD **03/15/2023**



Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number

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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 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	*	*			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	
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						

See below.

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.

Reviewed Vaccines

Vaccine Type	Date	Age	Amt.	Route	Site	NDC	Lot #	Mfr.	Exp. Date	VIS	VIS Given	Vaccinator
Diphtheria, Tetanus, Pertussis												
DTaP	07/22/19	6m3w										
DTaP	03/12/19	1y1mo										
DTaP	08/27/18	7m3do										
DTaP-Hib-IPV	03/30/18	2m6do										
Haemophilus Influenzae Type B												
Hib	02/24/20	2y1mo										
Hib	07/30/18	6m6do										
Hib	07/09/18	6m2do										
DTaP-Hib-IPV	03/30/18	2m6do										
Hepatitis A												