



VES PreSchool/School Readiness Program
~ Non-Resident Eligibility ~
2022-2023

Our Voluntown School Readiness Council has voted to allow non-residents into our School Readiness/Preschool Program for the upcoming school year, due to our low enrollment. *Voluntown residents will have enrollment priority.*

We are looking for typically developing peer models to join our School Readiness/Preschool Program. Non-resident Preschool screenings will take place on **Friday, June 17, 2022.**

We have spaces available for three, four and five year olds that are not eligible for Kindergarten. Students that turn 5 on or before January 1, 2023 are eligible for Kindergarten, so cannot be enrolled at Voluntown Elementary School.

Typically, we offer **FREE** part-day sessions in the morning (8:50-11:25am) and afternoon (12:45-3:20pm), Monday through Friday. Lunch is included free of charge.

Please note, there may be changes to our session offerings, lunch and transportation based on current health data. All changes will be communicated with families prior to the start of preschool.

If your child turns 3 on or before January 1, 2023, please contact our front office for information or visit our website after May 1, 2022. The screening is the first step to be placed in the lottery as a typically developing peer model.

Thank you,

Amy L. Suffoletto
Principal / School Readiness Liaison
asuffoletto@voluntownct.org



VES School Readiness/Preschool Program
~ 2022-2023 Resident Eligibility ~

Dear Voluntown Residents,

The Voluntown School Readiness/Preschool Program is accepting eligible resident preschool age children. Children may attend at the age of 2 years 9 months in the fall and must turn 3 by January 1, 2022. **There are spaces available for three, four and five year olds (not eligible for Kindergarten).** Students that turn 5 on or before January 1, 2023 are eligible for Kindergarten.

Registration in our PreSchool/School Readiness Program for Voluntown Residents is based on a **first-come, first-serve, rolling admission basis** and is accepted year round for eligible children.

Program Enrollment Guidelines:

1. Students do not need to be potty-trained to attend the programs. We work with families to prepare their child(ren) for school in all aspects of their early learning and development.
2. Parents are encouraged to sign up their child(ren) during the preschool registration period starting **June 1st through June 30th**, as there are a limited number of spaces, however, we accept registrations throughout the school year for age eligible children.
3. Special Education students are given first priority.
4. Parental preference of AM or PM sessions can be requested but are not guaranteed. Students are placed in either the morning or afternoon PreSchool/School Readiness session based on transportation routes and travel time. Therefore, we are not able to honor all requests. Final placements are determined by the Transportation Coordinator and Administration.

We offer **FREE** part-day sessions in the morning (8:50-11:25am) and afternoon (12:45-3:20pm), Monday through Friday. Lunch is included free of charge.

Please note, there may be changes to our session offerings, lunch and transportation based on current health data. All changes will be communicated with families prior to the start of preschool.

For more information, visit our website www.voluntownct.org: School Readiness page. Please call or visit our front office after **May 1, 2022** for a registration packet and tour information. Any questions, please email Amy Suffoletto, asuffoletto@voluntownct.org or Shawna Stephanski, sstephanski@voluntowncrt.org School Secretary, for enrollment information.

Thank you from our School Readiness/Preschool Staff!

Amy L. Suffoletto
Principal / School Readiness Liaison
asuffoletto@voluntownct.org

Toula Wyland
Preschool Teacher
twyland@voluntownct.org

Alyssa Fisher
Preschool Teacher
afisher@voluntownct.org

**Voluntown Elementary School
Parent/Guardian Registration Checklist**

PreSchool/School Readiness Parent/Guardian Registration Checklist

Please bring the following items with you to PreSchool/School Readiness Registration:

- _____ Parent/Guardian's Valid Driver's License
- _____ Child's Official Birth Certificate
- _____ Child's Insurance Card
- _____ Custody Paperwork, if applicable
- _____ Residency Affidavit and 2 Forms of Proof of Voluntown Residency (Acceptable forms include: proof of home ownership, lease or rental agreement, real estate tax bill/statement, gas/electric/oil/water/cable utility bill, or notarized affidavit of legal residence). ****Non-residents need 2 forms of Proof of CT Residency.**
- _____ Completed CT State Early Childhood Health Assessment Record (EC HAR) -- Must be completed by a pediatrician to show proof of immunizations and physical exam.

Per Office of Early Childhood School Readiness requirements, Parent/guardian MUST read and initial one of the following regarding influenza vaccine to enroll in our Preschool Program.

- _____ Connecticut immunization regulation requires at a minimum 1 dose of influenza vaccine for school entry, each year between August 1st and December 31st. A medical certificate is required by December 31st for reentry into school.
- _____ Completed medical or religious exemption forms from the CTSDE. Religious form **MUST** be submitted when the child enrolls in school.

In the PreSchool/School Readiness Registration Packet (you will receive this at the time of your registration appointment), please bring the completed items back to VES as soon as possible/by August 18, 2021.

- _____ Registration Form/Student Information Sheet
- _____ Release of Records Form (If they were at another school for PK)
- _____ Student Services Department (If applicable Authorization for Exchange of Records and Information Form)
- _____ Yearly Health Report Form

Per Connecticut Office of Early Childhood School Readiness Grant requirements, families must provide documentation of family gross income. Per the Voluntown School Readiness Council, families must complete a School Lunch Application. These must be submitted with your application. If applications are not included in the packet they will be sent home when they become available.

- _____ Copy of IRS tax return (preferred- front page only) or copy of most recent pay stubs.
- _____ Completed Lunch Application

VOLUNTOWN ELEMENTARY SCHOOL

REGISTRATION FORM / STUDENT INFORMATION SHEET

Last Name _____ First Name _____ Middle Name _____

House/Apt # _____ Street _____ Mailing: _____

Town _____ State _____ Zip _____ Phone _____

DOB _____ Male _____ Female _____ Social Security # _____

Bus # _____ Teacher _____ Grade _____

The following information is important for state and federal grant statistics: RACE/ETHNICITY

Am. Indian _____ Asian American _____ Black _____ Hispanic _____ White _____

Parent 1 _____ Phone _____

Parent 1: address if Non-Custodial

Place of Employment _____ Work Phone _____

e-mail address _____ Cell _____

Parent 2 _____ Phone _____

Parent 2 address if Non-Custodial

Place of Employment _____ Work Phone _____

e-mail address _____ Cell _____

Are you a member of the armed forces? Mother _____ Yes No _____ Father _____ Yes No _____

Signature of Parent/Legal Guardian/FosterParent _____ Date _____

PLEASE COMPLETE REVERSE SIDE

(ALS 7/14/22)

VOLUNTOWN ELEMENTARY SCHOOL

REGISTRATION FORM / STUDENT INFORMATION SHEET

Child's Doctor _____ Phone _____

Child's Dentist _____ Phone _____

Health Insurance ____ Yes No ____ Name of Insurance Co. _____

Policy # _____

****Any legal documentation for custody, restraining orders, etc., must be updated in your child's files on a yearly basis.**

☐ **Custody/restraining/other orders currently on file.**

Last Name _____ First Name _____ Grade _____

Please fill out the following information. List the names of the people you would allow to pick your child up from school or from the bus. (Step-parents' and grandparents' names should be included here if they are allowed to pick them up.)

Emergency name _____ Relationship _____ Phone _____

Cell _____

Emergency name _____ Relationship _____ Phone _____

Cell _____

Emergency name _____ Relationship _____ Phone _____

Cell _____

Emergency name _____ Relationship _____ Phone _____

Cell _____

Emergency Closing Instructions for **Daycare, Preschool/School Readiness and K students:**

PLEASE COMPLETE REVERSE SIDE

(ALS 7/14/22)

Voluntown Public Schools
Voluntown, CT 06384

Residency Affidavit

Available for download at www.voluntownct.org

I hereby certify that _____, date of birth _____,
student's name
resides with me at _____ in _____ and is a
student's street address *city/town*

bona fide permanent resident of Voluntown, Connecticut in accordance with Public Act 86-303.

As the parent/legal guardian of the above student, I am requesting his/her enrollment as a student at Voluntown Elementary School or at a Voluntown designated high school. I fully understand that I am obligated to inform the school principal (or Superintendent of Schools in the case of a high school student) immediately of any change in his/her residency status.

I realize that Connecticut Public Act 86-303 entitles a school district to deny enrollment if it suspects the enrollee is not a bona fide resident, and that the enrollee is entitled to a due process hearing before the Voluntown Board of Education if he/she wishes to appeal the decision.

Required Documentation – Please check the two items provided as proof of residency:

____ Lease or Rental Agreement ____ Proof of Home Ownership
____ Utility Bill ____ Driver's License
____ Other (please explain): _____

Signature of parent/legal guardian

Date



Voluntown Public School
195 Main Street
Voluntown, Connecticut 06384
Tel: (860) 376-4720 Fax: (860) 376-6690

Dr. Lloyd A. Johnson, Ph. D.
Director of Student Support Services

Authorization to Release, Obtain, and/or Exchange Information

Date: _____ Student's Name _____

Date of Birth: _____ Grade: _____

Address: _____

(Street)

(City,)

(State)

(Zip Code)

I hereby authorize: Voluntown Public Schools

☐ To Obtain from ☐ Release to and/or ☐ Exchange the specific information and/or records identified below to:

Name : _____

Name of Agency/Company : _____

Address: _____

(Street)

(City,)

(State)

(Zip Code)

(Phone)

This disclosure is being made for the following purpose(s):

- ☐ Educational Planning
☐ School Related Health Information
☐ Further Medical Information Needs
☐ At the Request of an Individual
☐ Other _____

Information to be Released:

- | | | |
|--------------------------------------------------------------------------|----------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Official Student Academic/Admin Rpt. | <input type="checkbox"/> Appropriate Agency Reports | <input type="checkbox"/> Social Work Report |
| <input type="checkbox"/> Special Education & Related Evaluations Reports | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Staff Observations |
| <input type="checkbox"/> Current IEP and Eligibility | <input type="checkbox"/> School Health Records | <input type="checkbox"/> Additional Medical History |
| <input type="checkbox"/> Psychological Reports | <input type="checkbox"/> Initial Intake & progress notes | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Phone Consultation | <input type="checkbox"/> Other _____ | |

Please check the following to indicate understanding of this authorization:

- ☐ Takes effect the day I sign it and cannot exceed one year from this date of this signature
☐ Can be stopped any time by sending a written request to Voluntown Public Schools, Director of Student Support Services

I further understand (please check the following to indicate understanding):

- ☐ I may refuse to sign this authorization and it will not affect my child's ability to receive educational services
☐ The laws that protect the information identified on this release, in some situations, may allow or require this entity to redisclose this information, but only as permitted by law
☐ A photostatic copy of this authorization shall be considered as effective and valid as the original, and
☐ I will receive a copy of this authorization.

Signature: _____
Parent/guardian/ legal representative or student

Date: _____
(mm/dd/yy)

VOLUNTOWN ELEMENTARY SCHOOL

YEARLY HEALTH REPORT 2022/2023

Student _____ DOB ____ / ____ / ____ Grade ____ Teacher _____

Home Phone _____ Parent Name #1- _____ #2 _____

Parent #1 Daytime phone # _____ Parent #2 Daytime phone # _____
Emergency # _____

Childs' Doctor _____ Date of last visit _____

Does your child have Asthma? Yes ____ No ____

If yes, please describe triggers, frequency and symptoms: _____
What medication is prescribed for this? _____

Does your child have a bee or insect sting allergy? Yes ____ No ____ Never Stung ____

If yes, please check type of reaction: Local swelling ____ Treatment ____
Hives, Difficulty breathing, Anaphylaxis ____ Treatment ____

Does your child have any food, medication, or environmental allergies? Yes ____ No ____

If yes please describe allergy and reaction _____
Medication needed? _____

Does your child have any other medical condition that we need to know about? _____

Does your child have any vision or hearing difficulties? _____

Glasses or contact lenses? Yes ____ No ____ Hearing aids? Yes ____ No ____

*Does your child take any medication? _____

For what reason? _____

Are you interested in school dental services for your child? Yes ____ No ____

(These services are readily available through UCFS for students on Ct Husky--- #860-892-7042 X346)

***A Medication Authorization Form to give medication must be filled out by your doctor, signed by you and given to the nurse before any medication (including over the counter) can be given at school. Students are not allowed to bring medication to school unless an emergency plan is in place.**

In the event that a parent/guardian or emergency contact person cannot be reached, I give permission for emergency medical treatment to be given to my child. Yes ____ No ____

Parent/Guardian Signature _____ Date _____



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

IMMUNIZATION REQUIREMENTS FOR ENROLLED STUDENTS IN CONNECTICUT SCHOOLS

2022-2023 SCHOOL YEAR



PRESCHOOL

| | |
|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Hep B: | 3 doses, last one on or after 24 weeks of age |
| DTaP: | 4 doses (by 18 months for programs with children 18 months of age) |
| Polio: | 3 doses (by 18 months for programs with children 18 months of age) |
| MMR: | 1 dose on or after 1 st birthday |
| Varicella: | 1 dose on or after 1 st birthday or verification of disease |
| Hepatitis A: | 2 doses given six calendar months apart, 1 st dose on or after 1 st birthday |
| Hib: | 1 dose on or after 1 st birthday |
| Pneumococcal: | 1 dose on or after 1 st birthday |
| Influenza: | 1 dose administered each year between August 1 st -December 31 st (2 doses separated by at least 28 days required for those receiving flu for the first time) |

KINDERGARTEN

| | |
|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Hep B: | 3 doses, last dose on or after 24 weeks of age |
| DTaP: | At least 4 doses. The last dose must be given on or after 4 th birthday |
| Polio: | At least 3 doses. The last dose must be given on or after 4 th birthday |
| MMR: | 2 doses separated by at least 28 days, 1 st dose on or after 1 st birthday |
| Varicella: | 2 doses separated by at least 3 months-1 st dose on or after 1 st birthday; or verification of disease. 28 days between doses is acceptable if the doses have already been administered. |
| Hepatitis A: | 2 doses given six calendar months apart, 1 st dose on or after 1 st birthday |
| Hib: | 1 dose on or after 1 st birthday for children less than 5 years old |
| Pneumococcal: | 1 dose on or after 1 st birthday for children less than 5 years old |

GRADES 1-6

| | |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Hep B: | 3 doses, last dose on or after 24 weeks of age |
| DTaP/Td: | At least 4 doses. The last dose must be given on or after 4 th birthday. Students who start the series at age 7 or older only need a total of 3 doses. |
| Polio: | At least 3 doses. The last dose must be given on or after 4 th birthday |
| MMR: | 2 doses separated by at least 28 days, 1 st dose on or after 1 st birthday |
| Varicella: | 2 doses separated by at least 3 months-1 st dose on or after 1 st birthday; or verification of disease. 28 days between doses is acceptable if the doses have already been administered. |
| Hepatitis A: | 2 doses given six calendar months apart, 1 st dose on or after 1 st birthday |

GRADE 7-10

| | |
|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Hep B: | 3 doses, last dose on or after 24 weeks of age |
| Tdap/Td: | 1 dose for students who have completed their primary DTaP series. Students who start the series at age 7 or older only need 3 doses of tetanus-diphtheria containing vaccine, one of which must be Tdap |
| Polio: | At least 3 doses. The last dose must be given on or after 4 th birthday |
| MMR: | 2 doses separated by at least 28 days, 1 st dose on or after 1 st birthday |
| Varicella: | 2 doses separated by at least 3 months-1 st dose on or after 1 st birthday; or verification of disease. 28 days between doses is acceptable if the doses have already been administered. |
| Hepatitis A: | 2 doses given six calendar months apart, 1 st dose on or after 1 st birthday |
| Meningococcal: | 1 dose |

GRADES 11-12

| | |
|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Hep B: | 3 doses, last dose on or after 24 weeks of age |
| Tdap/Td: | 1 dose for students who have completed their primary DTaP series. Students who start the series at age 7 or older only need 3 doses of tetanus-diphtheria containing vaccine, one of which must be Tdap |
| Polio: | At least 3 doses. The last dose must be given on or after 4 th birthday |
| MMR: | 2 doses separated by at least 28 days, 1 st dose on or after 1 st birthday |
| Varicella: | 2 doses separated by at least 3 months-1 st dose on or after 1 st birthday; or verification of disease. 28 days between doses is acceptable if the doses have already been administered. |
| Meningococcal: | 1 dose |

- DTaP vaccine is not administered on or after the 7th birthday.
- Tdap can be given in lieu of Td vaccine for children 7 years and older unless contraindicated.
- Hib is required for all Pre-K and K students less than 5 years of age.
- Pneumococcal Conjugate is required for all Pre-K and K students less than 5 years of age.
- Hep A requirement for school year 2022-2023 applies to all Pre-K through 10th graders born 1/1/07 or later.
- Hep B requirement for school year 2022-2023 applies to all students in grades K-12.
Spacing intervals for a valid Hep B series: at least 4 weeks between doses 1 and 2; 8 weeks between doses 2 and 3; at least 16 weeks between doses 1 and 3; dose 3 must be administered at 24 weeks of age or later.
- Second MMR for school year 2022-2023 applies to all students in grades K-12.
- Meningococcal Conjugate requirement for school year 2022-23 applies to all students in grades 7-12
- Tdap requirement for school year 2022-2023 applies to all students in grades 7-12
- If two live virus vaccines (MMR, Varicella, MMRV, Intra-nasal Influenza) are not administered on the same day, they must be separated by at least 28 days (there is no 4 day grace period for live virus vaccines). If they are not separated by at least 28 days, the vaccine administered second must be repeated.
- Lab confirmation of immunity is **only** acceptable for Hep A, Hep B, Measles, Mumps, Rubella, and Varicella.
- **VERIFICATION OF VARICELLA DISEASE:** Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

For the full legal requirements for school entry visit:

<https://portal.ct.gov/DPH/Immunizations/Immunization--Laws-and-Regulations>

If you are unsure if a child is in compliance, please call the Immunization Program at (860) 509-7929.

New Entrant Definition:

*New entrants are any students who are new to the school district, including **all** preschoolers and all students coming in from Connecticut private, parochial and charter schools located in the same or another community. **All pre-schoolers, as well as all students entering kindergarten**, including those repeating kindergarten, and those moving from any public or private pre-school program, even in the same school district, **are considered new entrants**. The one exception is students returning from private approved special education placements—they are not considered new entrants.

Commonly Administered Vaccines:

| <u>Vaccine:</u> | <u>Brand Name:</u> | <u>Vaccine:</u> | <u>Brand Name:</u> |
|--------------------|--------------------|-----------------|-----------------------------------------------|
| DTaP-IPV-Hib | Pentacel | MMRV | ProQuad |
| DTaP-HIB | TriHibit | PCV7 | Pevnar |
| HIB-Hep B | Comvax | PCV13 | Pevnar 13 |
| DTaP-IPV-Hep B | Pediarix | DTaP-IPV | Kinrix, Quadracel |
| Hepatitis A | Havrix, Vaxta | Influenza | Fluzone, FluMist, Fluviron, Fluarix, FluLaval |
| DTaP-IPV-Hib-Hep B | Vaxelis | | Flucelvax, Afluria |



**Voluntown
Elementary
School**

P.O. Box 129
195 Main Street
Voluntown, CT 06384-1821
860/376-2325
Fax 860/376-6690

August 2022

Dear Parents and Guardians,

Every year, at the beginning of the school year and upon any enrollment during the school year, we must inform parent/guardian(s), in writing, of his or her obligations under section 10-184 of the Connecticut General Statutes (see below).

Sec. 10-184. Duties of parents. School attendance age requirements.

All parents and those who have the care of children shall bring them up in some lawful and honest employment and instruct them or cause them to be instructed in reading, writing, spelling, English grammar, geography, arithmetic and United States history and in citizenship, including a study of the town, state and federal governments. Subject to the provisions of this section and section 10-15c, each parent or other person having control of a child five years of age and over and under eighteen years of age shall cause such child to attend a public school regularly during the hours and terms the public school in the district in which such child resides is in session, unless the parent or person having control of such child is able to show that the child is elsewhere receiving equivalent instruction in the studies taught in the public schools. The parent or person having control of a child five years of age shall have the option of not sending the child to school until the child is six years of age and the parent or person having control of a child six years of age shall have the option of not sending the child to school until the child is seven years of age. The parent or person shall exercise such option by personally appearing at the school district office and signing an option form. The school district shall provide the parent or person with information on the educational opportunities available in the school system.

Sincerely,

Amy L. Suffoletto
Principal


 access health CT


Does Your Family Need Health Insurance?

Connecticut offers low-cost or free coverage!

Dear Parent / Guardian,

Is your child protected by health insurance? If not, your school and the State of Connecticut want to help.

Connecticut's HUSKY Health program, for example, pays for doctor visits (including physical exams), prescriptions, emergency care, vision and dental care, mental healthcare, special healthcare needs and more. It's for children under age 19 in families of all incomes. Approximately 300,000 Connecticut children now have their healthcare covered by the HUSKY Health program. There are two parts to the HUSKY Health program for children:

- I. HUSKY A (or Medicaid) - For children in families with limited income. Parents, relative caregivers and pregnant women may also be eligible.
- II. HUSKY B (or Children's Health Insurance Program) - For children in families with higher incomes.

You can apply for HUSKY A or HUSKY B any time of the year.

- To apply online, please visit AccessHealthCT.com
- To apply by phone, please call 855-394-2428 (If you are deaf or hearing impaired, you may use the TTY at 1-855-789-2428 or contact us with a relay operator.)
- For general information about HUSKY Health, please visit www.ct.gov/Husky

Your child needs YOU to stay healthy, too!

When you apply for HUSKY Health for your child, see what Access Health CT has to offer you.

Most Connecticut residents have to wait until the next Open Enrollment period (November 1, 2021 - December 15, 2021) to get healthcare coverage through Access Health CT. You may be able to get coverage earlier if you have a Qualifying Life Event OR if you qualify for Medicaid (HUSKY A or D) or CHIP (HUSKY B).

What is a Qualifying Life Event? Qualifying Events include:



(May 1 – Aug 15) Residents who are under-insured, uninsured, or want to receive newly available financial help



Newly eligible/ineligible for Premium Tax Credits as a result of Divorce, or other Legal Decree or Court Order



Marriage

> Loss of Coverage Due to Other Circumstances:



Permanent move to Connecticut

- Expiration of COBRA
- No longer eligible for HUSKY Health
- No longer eligible for an Advance Premium Tax Credit (APTC) or a Cost-Sharing Reduction (CSR)
- Change in citizenship or lawful presence status



Pregnancy, birth, adoption or foster care

For More Information, visit AccessHealthCT.com

HOW CAN WE HELP YOU?

When you're looking for:

- Food
- Shelter
- Child Care
- Crisis Intervention
- Disability Services
- Drug/Alcohol Programs
- Energy Assistance
- Health Care
- Job Training
- Legal Assistance
- Literacy Classes
- Parenting Programs
- Senior Services
- Support Groups
- Tax Assistance
- Transportation
- Veteran's Services
- and much more**



Get Connected. Get Answers.

www.211ct.org
or Dial 2-1-1

United Way 2-1-1 can help. Whether by phone or online, 2-1-1 will connect you to health and human services resources for everyday needs and in times of crisis.

2-1-1 is free of charge, open 24/7 all year and has professionally-trained contact specialists to assess caller's needs with translation services available in many languages.

2-1-1 is certified by the American Association of Suicidology for crisis intervention and accredited by the Alliance of Information and Referral Systems.

Free...Confidential.....
24 Hours a Day Every
Day.....Multilingual/TTY

CONNECT WITH
HELP AT
www.211ct.org
OR DIAL 2-1-1

Out-of-State: 1-800-203-1234
TTY: 800-671-0737



2-1-1 is supported by the State of Connecticut and Connecticut United Ways.

¿NECESITA AYUDA O INFORMACIÓN?

Cuando usted está buscando:

- Alimentos
- Vivienda
- Cuidado de Niños
- Intervención de Crisis
- Servicios para Incapacitados
- Programas de Drogas/Alcohol
- Ayuda de Energía
- Capacitación laboral
- Ayuda Legal
- Ayuda Tributaria
- Servicios para Personas Mayores
- Transportación
- Servicios de Veteranos
- **y mucho más**

United Way 2-1-1 puede ayudar. Ya sea por teléfono o en línea, 2-1-1 le conectará con los recursos de salud y servicios humanos para las necesidades diarias y en tiempos de crisis.

2-1-1 es gratis, abierta 24/7 durante todo el año y ha profesionalmente capacitados especialistas de contacto para evaluar las necesidades de las personas que llaman con servicios de traducción disponibles en muchos idiomas.

2-1-1 es certificado por la Asociación Norteamericana de Suicidología para la intervención de crisis y acreditados por la Alianza de Información y Sistemas de Referencia.

www.211ct.org
O Marque el 2-1-1



Gratis....Confidencial....
**24 Horas al Día todos los
Días....Multilingüe/TTY**

CONÉCTATE CON AYUDA EN
www.211GT.ORG
O MARQUE EL 2-1-1

Fuera del Estado: 1-800-203-1234
TTY: 800-671-0737



2-1-1 es apoyado por el Estado de Connecticut y Connecticut United Ways.



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) | Birth Date (mm/dd/yyyy) | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Address (Street, Town and ZIP code) | | |
| Parent/Guardian Name (Last, First, Middle) | Home Phone | Cell Phone |
| Early Childhood Program (Name and Phone Number) | Race/Ethnicity <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Other <input type="checkbox"/> Hispanic/Latino of any race | |
| Primary Health Care Provider: | | |
| Name of Dentist: | | |
| 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 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 | 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

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

Part 2 — Medical Evaluation

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

Child's Name _____ Birth Date _____ Date of Exam _____
 (mm/dd/yyyy) (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 _____ in/cm _____ % *Weight _____ lbs. _____ oz. / _____ % BMI _____ / _____ % *HC _____ in/cm _____ % *Blood Pressure _____ / _____
 (Birth-24 months) (Annually at 3-5 years)

Screenings

| | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-------|----------------|-------|
| *Vision Screening <input type="checkbox"/> EPSDT Subjective Screen Completed (Birth to 3 yrs.) <input type="checkbox"/> EPSDT Annually at 3 yrs. (Early and Periodic Screening, Diagnosis and Treatment) Type: <u>Right</u> <u>Left</u> With glasses 20/ 20/ Without glasses 20/ 20/ <input type="checkbox"/> Unable to assess <input type="checkbox"/> Referral made to: _____ | *Hearing Screening <input type="checkbox"/> EPSDT Subjective Screen Completed (Birth to 4 yrs.) <input type="checkbox"/> EPSDT Annually at 4 yrs. (Early and Periodic Screening, Diagnosis and Treatment) Type: <u>Right</u> <u>Left</u> <input type="checkbox"/> Pass <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Fail <input type="checkbox"/> Unable to assess <input type="checkbox"/> Referral made to: _____ | *Anemia: at 9 to 12 months and 2 years <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">*Hgb/Hct:</td> <td style="width: 50%;">*Date</td> </tr> </table> *Lead: at 1 and 2 years; if no result screen between 25 – 72 months History of Lead level ≥ 5µg/dL <input type="checkbox"/> No <input type="checkbox"/> Yes <hr/> <table style="width: 100%;"> <tr> <td style="width: 60%;">*Result/Level:</td> <td style="width: 40%;">*Date</td> </tr> </table> Other: _____ | *Hgb/Hct: | *Date | *Result/Level: | *Date |
| *Hgb/Hct: | *Date | | | | | |
| *Result/Level: | *Date | | | | | |
| *TB: High-risk group? <input type="checkbox"/> No <input type="checkbox"/> Yes Test done: <input type="checkbox"/> No <input type="checkbox"/> Yes Date: _____ Results: _____ Treatment: _____ | *Dental Concerns <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Referral made to: _____ Has this child received dental care in the last 6 months? <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | |

*Developmental Assessment: (Birth-5 years) ☐ No ☐ Yes Type:

Results:

***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.

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

Date Signed

Printed/Stamped Provider Name and Phone Number

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 |
| School | Grade | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Home Address | | |
| Parent/Guardian Name (Last, First, Middle) | Home Phone | Cell Phone |

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| Dental Examination Completed by: <input type="checkbox"/> Dentist | Visual Screening Completed by: <input type="checkbox"/> MD/DO <input type="checkbox"/> APRN <input type="checkbox"/> PA <input type="checkbox"/> Dental Hygienist | Normal <input type="checkbox"/> Yes <input type="checkbox"/> Abnormal (Describe) _____ _____ _____ _____ | Referral Made: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Risk Assessment <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High | Describe Risk Factors <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Dental or orthodontic appliance <input type="checkbox"/> Saliva <input type="checkbox"/> Gingival condition <input type="checkbox"/> Visible plaque <input type="checkbox"/> Tooth demineralization <input type="checkbox"/> Other _____ </div> <div> <input type="checkbox"/> Carious lesions <input type="checkbox"/> Restorations <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____ </div> </div> | | |

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 _____

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

Child's Name: _____ Birth Date: _____ REV. 1/2022

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 | | | | | | |

Religious Exemption: _____

Religious exemptions must meet the criteria established in Public Act 21-6: <https://www.ctoec.org/wp-content/uploads/2021/07/OEC-Vaccination-QA-Final.pdf>.

Medical Exemption: _____

Must have signed and completed medical exemption form attached. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf

Disease history of varicella: _____ (date); _____ (confirmed by)

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 | 2-3 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 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

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

Date Signed

Printed/Stamped Provider Name and Phone Number