

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health and Senior Services

| SECTION I - TO BE COMPLETED BY PARENT(S) | | | | | |
|--|----------------|---|---|---|------------------|
| Child's Name (Last) _____ (First) _____ | | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | | Date of Birth / / | |
| Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | | If Yes, Name of Child's Health Insurance Carrier _____ | | | |
| Parent/Guardian Name _____ | | Home Telephone Number _____ | | Work Telephone/Cell Phone Number _____ | |
| Parent/Guardian Name _____ | | Home Telephone Number _____ | | Work Telephone/Cell Phone Number _____ | |
| <i>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i> | | | | | |
| Signature/Date _____ | | | | This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER | | | | | |
| Date of Physical Examination: _____ | | Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Abnormalities Noted: _____ | | | Weight (must be taken within 30 days for WIC) | | |
| | | | Height (must be taken within 30 days for WIC) | | |
| | | | Head Circumference (if <2 Years) | | |
| | | | Blood Pressure (if ≥3 Years) | | |
| IMMUNIZATIONS | | <input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____ | | | |
| MEDICAL CONDITIONS | | | | | |
| Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns: | | <input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached | | Comments _____ | |
| Medications/Treatments • List medications/treatments: | | <input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached | | Comments _____ | |
| Limitations to Physical Activity • List limitations/special considerations: | | <input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached | | Comments _____ | |
| Special Equipment Needs • List items necessary for daily activities | | <input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached | | Comments _____ | |
| Allergies/Sensitivities • List allergies: | | <input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached | | Comments _____ | |
| Special Diet/Vitamin & Mineral Supplements • List dietary specifications: | | <input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached | | Comments _____ | |
| Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns: | | <input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached | | Comments _____ | |
| Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for: | | <input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached | | Comments _____ | |
| PREVENTIVE HEALTH SCREENINGS | | | | | |
| Type Screening | Date Performed | Record Value | Type Screening | Date Performed | Note if Abnormal |
| Hgb/Hct | | | Hearing | | |
| Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous | | | Vision | | |
| TB (mm of Induration) | | | Dental | | |
| Other: | | | Developmental | | |
| Other: | | | Scoliosis | | |
| <input type="checkbox"/> <i>I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.</i> | | | | | |
| Name of Health Care Provider (Print) _____ | | | Health Care Provider Stamp: | | |
| Signature/Date _____ | | | | | |