

# 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 _____
<b>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</b>			
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)	_____
<b>IMMUNIZATIONS</b>		<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		

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.

Name of Health Care Provider (Print) _____	Health Care Provider Stamp: _____
Signature/Date _____	