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 Male Female	Date of Birth / /

Does Child Have Health Insurance? Yes 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 give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. Yes No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:

Results of physical examination normal? Yes 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

Immunization Record Attached
Date Next Immunization Due:

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	None Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	None Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	None Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	None Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	None Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	None Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	None Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	None 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: Capillary 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	

CH-14 SEP 08

Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider