

UNIVERSAL CHILD HEALTH RECORD

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

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 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. <input type="checkbox"/> Yes <input type="checkbox"/> No		

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER	
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Date of Physical Examination:	Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Abnormalities Noted:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; padding: 5px;">Weight (must be taken within 30 days for WIC)</td> <td style="width: 30%;"></td> </tr> <tr> <td style="padding: 5px;">Height (must be taken within 30 days for WIC)</td> <td></td> </tr> <tr> <td style="padding: 5px;">Head Circumference (if <2 Years)</td> <td></td> </tr> <tr> <td style="padding: 5px;">Blood Pressure (if >3 Years)</td> <td></td> </tr> </table>	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)	
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Blood Pressure (if >3 Years)									

IMMUNIZATIONS	<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____
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MEDICAL CONDITIONS		
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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					
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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	