

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