

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 ☐ 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:	<table border="1"> <tr> <td>Weight (must be taken within 30 days for WIC)</td> <td></td> </tr> <tr> <td>Height (must be taken within 30 days for WIC)</td> <td></td> </tr> <tr> <td>Head Circumference (if <2 Years)</td> <td></td> </tr> <tr> <td>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

- ☐ 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	