

# 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	
<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. 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)			
<b>IMMUNIZATIONS</b>		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		
T B (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		
<b>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.</b>					
Name of Health Care Provider (Print)			Health Care Provider Stamp:		
Signature/Date					