

# 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		
<b>PREVENTIVE HEALTH SCREENINGS</b>						
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		
<input type="checkbox"/> 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						