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:	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)*	

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	

Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

New Jersey Department of Health

STANDARD SCHOOL / CHILD CARE CENTER IMMUNIZATION RECORD

NAME OF CHILD (Last, First, MI)	DATE OF BIRTH (Mo/Day/Yr)	SEX ☐ M ☐ F
NAME OF PARENT/GUARDIAN	TELEPHONE NUMBER(S)	
ADDRESS		
ADDRESS	IMMUNIZATION REGISTRY NUMBER	

VACCINE TYPE	1ST DOSE MO/DAY/YR	2ND DOSE MO/DAY/YR	3RD DOSE MO/DAY/YR	4TH DOSE MO/DAY/YR	5TH DOSE MO/DAY/YR	EXEMPTIONS
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT[1], indicate in corner box)						☐ Medical Exemption Attached
POLIO-INACTIVATED POLIO VACCINE (IPV) (If oral vaccine, indicate OPV in corner box)						☐ Religious Exemption Attached
MEASLES, MUMPS, RUBELLA (MMR)					[5] Document below single antigen vaccine receipt, serology titers, or varicella disease history	
HAEMOPHILUS B (HIB)						
HEPATITIS B (HepB)					Hepatitis B	DATE: TITER:
VARICELLA					Varicella	DATE: TITER:
PNEUMOCOCCAL CONJUGATE (PCV13)					Measles	DATE: TITER:
INFLUENZA					Mumps	DATE: TITER:
OTHER, SPECIFY:					Rubella	DATE: TITER:
OTHER, SPECIFY:					Comments:	
OTHER, SPECIFY:						

☐ Provisional Admission Date Granted: ___ ___ / ___ ___ / ___ ___ ___ ___

[1] REQUIRES MEDICAL EXEMPTION.

A complete list of New Jersey's immunization requirements is accessible at: http://nj.gov/health/cd/imm_requirements

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List any contagious diseases your child has had: _____

Has your child had frequent ear infections? _____

Allergies: _____

Physical and/or emotional handicaps: _____

Is this child physically, mentally and emotionally prepared to participate in group activities on a nursery school level? _____

Doctor's comments: _____

Doctor's signature _____

Parent's signature _____