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 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 11 - 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:	El None • Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	• None El Special Care Plan Attached Comments	
Limitations to Physical Activity • List limitations/special considerations:	• None El Special Care Plan Attached Comments	
Special Equipment Needs • List items necessary for daily activities	• None El Special Care Plan Attached Comments	
Allergies/Sensitivities • List allergies:	El None • Special Care Plan Attached Comments	
Special DietNitamin & Mineral Supplements • List dietary specifications:	• None • Special Care Plan Attached Comments	
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	El 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	

CH-14 SEP 08 Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider