



MANASQUAN SCHOOL DISTRICT

Health Service Team

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UNIVERSAL CHILD HEALTH RECORD

*Endorsed by: American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health*

Below, please find the copy of the Physical Examination Form that is necessary to register your child for school. The parent/guardian should complete Section I of the form and then submit the form for Section II to be completed by your child's physician.

Please take note of the following:

- **Please attach a copy of immunizations to this form.**
For incoming PreK 3 & 4 students aged 6 – 59 months on or before December 31, evidence of an Influenza (Flu) vaccination is mandatory before December 31 to enter and remain in the program.
- **Physicals must be completed no more than 365 days prior to the entrance of school.**
- **Vision and Hearing Screening must be completed to be considered a valid physical.**
- **For incoming Kindergarten students, please submit by June 1. If your child turns 5 after June 1, please contact the school nurse.**
- **This form includes all the information required under [NJAC 6A:16-2.2](#) .**



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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>			
Parent/Guardian 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)		
IMMUNIZATIONS *Please attach*	<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____		
MEDICAL CONDITIONS			
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	Comments	



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	<input type="checkbox"/> Special Care Plan Attached	
Limitations to Physical Activity <ul style="list-style-type: none"> List limitations/special considerations: 	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Equipment Needs <ul style="list-style-type: none"> List items necessary for daily activities: 	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Allergies/Sensitivities <ul style="list-style-type: none"> List allergies: 	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements <ul style="list-style-type: none"> List dietary specifications: 	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis <ul style="list-style-type: none"> List behavioral/mental health issues/concerns: 	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Emergency Plans <ul style="list-style-type: none"> List emergency plan that might be needed for the sign/symptoms to watch for: 	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments

PREVENTATIVE HEALTH SCREENINGS
***Vision, Hearing and Dental Screenings are mandatory for students entering Pre-K**
Parent may submit separate proof of dental

Type of 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		

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 childcare/school activities, including physical education and competitive contact sports, unless noted above.

Name of Health Care Provider (Print)	Health Care Provider Stamp
Signature/Date	