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)					Gende	r		Date of B	irth		
					□ N	1ale 🗌	Female	e	/	/	
Does Child Have Health Insurance?	If Yes, N	lame of	Child's Health	Insu	ırance Ca	rrier					
□Yes □No											
Parent/Guardian Name Home Telep				one	one Number Work Telephone/Cell Phone Number						
(() -				() -			
Parent/Guardian Name Home			Home Teleph	one	Number			Work Telepho	ne/Cel	l Phone Number	
			() -					()	-	
I give my consent for my child's Health Care Provider and Child Ca						chool Nu	rse to d	liscuss the in	forma	tion on this form.	
Signature/Date								orm may be re			
					□Yes □No						
SECTION II - TO BE COMPLETED					Y HEALT	H CARE	PROV	IDER .			
										□No	
Date of Physical Examination: Results o Abnormalities Noted:					ysicai exa	,				Пио	
Abhormaniles Noted.						Weight (
				within 30 days for WIC) Height (must be taken							
					within 30 days for WIC)						
					Head Circumference						
					(if <2 Years)						
						Blood Pressure (if ≥3 Years)					
					\	(II <u>></u> 3 Ye	ars)				
IMMUNIZATIONS Immunization Rec											
Date Next Immunization Due: MEDICAL CONDITIONS											
MEDICAL CONDITIONS Chronic Medical Conditions/Related Surgeries											
List medical conditions/ongoing surgical concerns:			ial Care Plan	~	ommonto						
			hed								
Medications/Treatments			None			Comments					
List medications/treatments:		Special Care Plan Attached									
		None		C	Comments						
Limitations to Physical Activity List limitations/special considerations:		Special Care Plan									
List illilitations/special considerations.		Attached		_							
Special Equipment Needs List items necessary for daily activities		☑ None☑ Special Care Plan			Comments						
			Attached								
Allergies/Sensitivities • List allergies:		None		Comments							
			Special Care Plan Attached								
		None		C	Comments						
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:		Special Care Plan		•	Comments						
		Attac	hed								
Behavioral Issues/Mental Health Diagnosis		∐ None □ Spec		C	omments						
 List behavioral/mental health issues/concerns: 			ial Care Plan hed								
Emergency Plans		None			Comments						
			ial Care Plan								
the sign/symptoms to watch for: Attached											
PREVENTIVE HEAD Type Screening Date Performed Record Value											
Type Screening	Date Performed	Necora value				Screenin	g	Date Perform	nea	Note if Abnormal	
Hgb/Hct					Hearing Vision				+		
Lead:									+		
TB (mm of Induration)					Dental	montal			+		
Other:					Develop				+		
Other:			1 1-1-11	141	Scoliosis		·	- 4h1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		adiaalla des l	
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.											
7 7 7						ovider Star	•	ο σοπασι σμ	J. 13, UI	noted above.	
					v . 1		r .				
Signature/Date											
9											