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 ☐ 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	

WASHINGTON TOWNSHIP SCHOOL DISTRICT

Brass Castle School
16 Castle Street
Washington, NJ 07882
TELEPHONE: 908-689-1188 FAX: 908-689-2356

Student name______________________________ **Date of birth**____________________

IMMUNIZATION REQUIREMENTS (K through 8)

1. **DTP** (diphtheria, tetanus, & pertussis)- 4 doses, with one dose on or after the 4th birthday, or any 5 doses.
2. **Polio**- 3 doses, with one dose on or after the 4th birthday, or any 4 doses.
3. **MMR** (measles, mumps, rubella)- 2 doses.
4. **Varicella** (chicken pox)- 1 dose, on or after the 1st birthday.
5. **Hepatitis B**- 3 doses.
6. **Meningococcal**- 1 dose for 6th grade and higher.
7. **Tdap** (tetanus, diphtheria, acellular pertussis)- 1 dose for 6th grade and higher.

Dates must be completed **by your health care provider** in the spaces provided below before any child will be permitted to enter school.

PROOF OF IMMUNIZATION

DTP ________ ________ ________ ________ ________ Tdap__________

Polio ________ ________ ________ ________ MMR ________ ________

Varicella ________ ________ Hepatitis B ________ ________ ________ ________

Meningococcal ________ Influenza ____________ Other____________________

Printed Name/Address/Phone/Fax

______________________________ ____________________
Health Care Provider Signature Date