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)				irst)		Gender Date of Birth								
						□м	Femal	le	! !					
Does Child Have Health Insuran	ice? If Ye	s, Na	me o	f Child's He	alth	Insurance	e Carrier							
□Yes □No	□Yes □No													
Parent/Guardian Name	ne Home 1					ephone Number				Work Telephone/Cell Phone Number				
Parent/Guardian Name		$\overline{}$	Home Tele	ohone	hone Number			Work	Teleph	one/Ce	ell Phone N	umber		
I give my consent for my child	are P	rovider/S	chool Nurs											
Signature/Date									s form may be released to WIC.					
	☐Yes ☐No ED BY HEALTH CARE PROVIDER													
Date of Physical Examination: Results of physical examination normal? Yes No														
Apriormanues Noted.					Weight(must be taken within 30 days for WIC)									
						Height (must be taken								
						within 30 days for WIC)								
									erence					
						(if <2 Years) Blood Pressure								
							(if ≥3 Yea		c					
		$\neg \neg$	Immu	nization Rec	ord Af	ttached	s	-,						
IMMUNIZATIONS	ı—		Next Immunia											
				EDICAL C										
Chronic Medical Conditions/Relate	ed Surgeries	\Box	None			mments								
 List medical conditions/ongoing surgical concerns: 			Specia Attach	al Care Plan ed	1									
Medications/Treatments List medications/treatments:			None	10 5	Comments									
			Specia Attach	al Care Plan ed										
Limitations to Discolar Libraria			None		Co	mments								
List limitations/special considerations:			Special Care Plan Attached											
Special Equipment Needs List items necessary for daily activities			□None □Special Care Plan			mments								
			Special Care Plan Attached											
Allergies/Sensitivities • List allergies:			None			Comments								
			Special Care Plan Attached											
			None			Comments								
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:			Special Care Plan Attached											
						Comments								
Behavioral Issues/Mental Health Diagnosis List behavioral/mental health			None □ None			mments								
List benavioral/mental nealth issues/concerns:			Special Care Plan Attached											
Emergency Plans			None			Comments								
 List emergency plan that might be needed 			Special Care Plan											
and the sign/symptoms to wa	ich for:	_		itive HEA	I TH	SCREEN	UNGS							
Type Screening	Date Perform			ecord Value	_		Screening	a	Date	Perforn	ned	Note if Al	onormal	
Hgb/Hct	24.0 011011		- 10	- 30. a Taide		Hearing	20.0011111	d	Date	. onor				
Lead: Capillary Venous		\dashv				Vision					-+			
B (mm of Induration)						Dental								
Other:					mental				$\overline{}$					
Other:						Scoliosis					$\neg +$			
Name of Health Care Provider (Pr	int)				Hea		rovider Sta	amp:						
· ·														
Signature/Date														

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SECTION 1 - TO BE COMPLETED BY PARENT(S)													
Child's Name (Last)	rst)		Gende		Female		ate of E	Birth /		1			
Does Child Have Health Insurance? If Yes, Name of Child's Health Insurance Carrier													
Parent/Guardian Name		ŀ	Home Telephone Number					Work Telephone/Cell Phone Number					
Parent/Guardian Name	H	Home Telep	hone Number				Work Telephone/Cell Phone Number						
Laive my consent for my chil	nd Child Ca	ro Dr	ovidor/S	chool Nur	ren to n	diecue	e tho in	formet	ion on	this form			
I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to Signature/Date Thi									may be				
							Yes						
SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER													
Date of Physical Examination: Results of physical examination normal?													
Abnormalities Noted:		Weight(must be taken											
						days for WIC) must be taken							
						within 30							
				Head Circumference									
						(if <2 Years) Blood Pressu							
						(if ≥3 Yes							
IMMUNIZATIONS		Immun	ization Reco	rd Att	Attached								
IMMONIZATIONS	<u>'</u>		Date Next Immunization Due:										
MEDICAL CONDITIONS Chronic Medical Conditions/Related Surgeries None Comments													
List medical conditions/ongoil concerns:	☐None ☐Special Care Plan Attached		~	IIIIIciiia									
Medications/Treatments • List medications/treatments:	□None □Specia Attache	Co	mments										
Limitations to Physical Activity • List limitations/special consid	□None □Specia Attache	Co	mments										
Special Equipment Needs • List items necessary for daily	□None □Specia Attache	Co	mments										
Allergies/Sensitivities • List allergies:	□None □Specia Attache		Comments										
Special Diet/Vitamin & Mineral Su • List dietary specifications:	□None □Specia Attache		mments										
 Behavioral Issues/Mental Health I List behavioral/mental health issues/concerns: 	□None □Specia Attache	Co	Comments										
Emergency Plans List emergency plan that might and the sign/symptoms to war	□None □Special Care Plan Attached		Co	Comments									
2 2 1			TIVE HEAL	TH :	SCREEN	NINGS				_			
Type Screening	Date Performe	d Re	cord Value	\Box		Screening	g	Date	Perfor	ned	Note i	f Abnormal	
Hgb/Hct				$\overline{}$	Hearing		-						
Lead: Capillary Venous				-	Vision		+						
B (mm of Induration)				\rightarrow	Dental Developmental					-+			
Other:			-	Scoliosis					-+				
Name of Health Care Provider (Pr	<u> </u>				rovider Sta	amp:							
Signature/Date													