

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 1 - TO BE COMPLETED BY PARENT(S)

CHILD NAME: (LAST)	(FIRST)	DATE OF BIRTH: / /
DOES CHILD HAVE HEALTH INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, NAME THE CHILD'S HEALTH INSURANCE CARRIER	
PARENT/GUARDIAN NAME	HOME PHONE NUMBER	WORK NUMBER/ MOBILE NUMBER
PARENT/GUARDIAN NAME	HOME PHONE NUMBER	WORK NUMBER/ MOBILE 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 <input type="checkbox"/> YES <input type="checkbox"/> NO	

SECTION 2 - TO BE COMPLETED BY HEALTH CARE PROVIDER

DATE OF PHYSICAL EXAMINATION:	RESULT OF PHYSICAL EXAMINATION NORMAL? <input type="checkbox"/> YES <input type="checkbox"/> NO
ABNORMALITIES NOTED:	WEIGHT (MUST BE TAKEN) WITHIN 30 DAYS FOR WIC
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	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:	<input type="checkbox"/> NONE <input type="checkbox"/> SPECIAL CARE PLAN ATTACHED	COMMENTS
MEDICATIONS/TREATMENTS ~ LIST MEDICATIONS/TREATMENTS:	<input type="checkbox"/> NONE <input type="checkbox"/> SPECIAL CARE PLAN ATTACHED	COMMENTS
LIMITATIONS TO PHYSICAL ACTIVITY ~ LIST LIMITATIONS/SPECIAL CONSIDERATIONS:	<input type="checkbox"/> NONE <input type="checkbox"/> SPECIAL CARE PLAN ATTACHED	COMMENTS
SPECIAL EQUIPMENT NEEDS ~ LIST ITEMS NECESSARY FOR DAILY ACTIVITIES	<input type="checkbox"/> NONE <input type="checkbox"/> SPECIAL CARE PLAN ATTACHED	COMMENTS
ALLERGIES SENSITIVITIES ~ LIST ALLERGIES	<input type="checkbox"/> NONE <input type="checkbox"/> SPECIAL CARE PLAN ATTACHED	COMMENTS
SPECIAL DIET/ VITAMIN & MINERAL SUPPLEMENTS ~ LIST DIETARY SPECIFICATIONS:	<input type="checkbox"/> NONE <input type="checkbox"/> SPECIAL CARE PLAN ATTACHED	COMMENTS
BEHAVIORAL ISSUES/ MENTAL HEALTH DIAGNOSIS ~ LIST BEHAVIORAL/ MENTAL HEALTH ISSUES/ CONCERNS:	<input type="checkbox"/> NONE <input type="checkbox"/> SPECIAL CARE PLAN ATTACHED	COMMENTS
EMERGENCY PLANS: ~ LIST EMERGENCY PLAN THAT MIGHT BE NEEDED AND THE SIGN/SYMPTOMS TO WATCH FOR:	<input type="checkbox"/> NONE <input type="checkbox"/> 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 <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 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	



LOOKING GLASS CHILDREN'S CENTER

CHILD CARE CENTER IMMUNIZATION RECORD

NAME OF CHILD (Last, First, MI)					DATE OF BIRTH (MO/DAY/YR)		SEX <input type="checkbox"/> M <input type="checkbox"/> F	
NAME OF PARENT / GUARDIAN					TELEPHONE NUMBER(S)			
ADDRESS								
ADDRESS					IMMUNIZATION REGISTRY NUMBER			
VACCINE TYPE	1ST DOSE MO/DAY/YR	2ND DOSE MO/DAY/YR	3RD DOSE MO/DAY/YR	4TH DOSE MO/DAY/YR	5TH DOSE MO/DAY/YR	LEAD SCREENING (Not Required)		
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT ¹ , indicate in corner box)						TEST DATE	RESULT	
POLIO-INACTIVATED POLIO VACCINE (IPV) (If oral vaccine, indicate OPV in corner box)								
MEASLES, MUMP2, RUBELLA (MMR)						(5) Document below single antigen vaccine receipt, serology titer, or Varicella disease history		
HAEMOPHILUS B (HIB) ⁽²⁾								
HEPATITIS B ⁽³⁾						Hepatitis B	DATE:	TITER:
VARICELLA ⁽⁴⁾						Varicella	DATE:	TITER:
PNEUMOCOCCAL CONJUGATE ⁽²⁾						Measles	DATE:	TITER:
INFLUENZA ⁽⁶⁾						Mumps	DATE:	TITER:
OTHER, SPECIFY:						Rubella	DATE:	TITER:
<input type="checkbox"/> Provisional Admission Attached - Date Granted: _____ <input type="checkbox"/> Medical Exemption Attached <input type="checkbox"/> Religious Exemption Attached								

PHYSICAL EXAMINATION:

General Observations: _____

Is there any reason the child cannot participate or should not participate in any or all age-appropriate school activities? _____ If "Yes", please specific any restrictions:

I have examined the above-named child and have found the child to be physically fit to be admitted to Looking Glass Children's Center, and participate in all activities without risk either to the child or to the school.

Physician's Signature: _____
 Address: _____

 Phone: _____
 Date: _____

