

# UNIVERSAL CHILD HEALTH RECORD

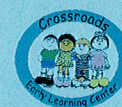
Endorsed by:  
American Academy of Pediatrics, New Jersey Chapter  
New Jersey Academy of Family Physicians  
New Jersey Department of Health and Senior Services

## SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name (Last)	(First)	Gender <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>			
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)				
<b>IMMUNIZATIONS</b>	<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due:				
<b>MEDICAL CONDITIONS</b>					
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				
<b>PREVENTIVE HEALTH SCREENINGS</b>					
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		
Name of Health Care Provider (Print)			Health Care Provider Stamp:		
Signature/Date					



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