UNIVERSAL CHILD HEALTH RECORD

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

Child's Name *(Last)*	*(First)*	Date of Birth / /
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

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		

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss a information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program f Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if th child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within th last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within th last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.
2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter th immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Departmer of Health and Senior Services, Immunization Program at 609-588-7512.
   - The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-dat with immunizations.
3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the chil care setting.
   a. **If the child has a complex medical condition, a special care plan should be completed and attached.** Note an significant medical conditions or major surgical history.
   b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's healt while in child care. (seizure, cardiac or asthma medications etc.) Short-term medications such as antibiotics do not need t be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigge medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may likely require separate permissions slips for prescription and OTC medications.*
   c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.
   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.
   e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.
   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.
   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.
   h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.
4. **Screening** - This section is required for school, WIC, Head Start and some other programs. This section may be optional for routine child care settings but can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.
5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

New Jersey Department of Health and Senior Services
STANDARD SCHOOL / CHILD CARE CENTER IMMUNIZATION RECORD

NAME OF CHILD (Last, First, MI)	DATE OF BIRTH (Mo./Day/Yr.)	SEX ☐M ☐F
NAME OF PARENT/GUARDIAN	TELEPHONE NUMBER(S)	
ADDRESS		
ADDRESS	IMMUNIZAITON 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)* TEST DATE	LEAD SCREENING *(Not Required)* RESULT
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT[1], indicate in corner box)							
POLIO-INACTIVATED POLIO VACCINE (IPV) (If oral vaccine, indicate OPV in corner box)							
MEASLES, MUMPS, RUBELLA (MMR)					[5] Document below single antigen vaccine receipt, serology titers, 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:

☐Provisional Admission Attached - Date Granted: _____ ☐Medical Exemption Attached ☐Religious Exemption Attached

[1] REQUIRES MEDICAL EXEMPTION.
[2] REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (2 Months - 5th Birthday Only)
[3] REQUIRED FOR K-GRADE 1 (whichever is first). GRADE 6 BEGINNING 9-1-01, AND GRADES 9-12, EFFECTIVE 9-1-04.
[4] REQUIRED FOR DAY/CHILD CARE ENROLLEES (19 Months and older) AND GRADE K-GRADE 1 (whichever is first) EFFECTIVE 9-1-04.
[5] MMR single antigen receipt requires MO/DAY/YR, serologies require titers, and varicella disease history requires MO/YR.
[6] REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (6 Months – 59 Months)