

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

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 / /
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. <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)

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		

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

STATE OF NEW JERSEY IMMUNIZATION REQUIREMENTS FOR SCHOOL ENTRANCE

IMMUNIZATIONS RECOMMENDATIONS

Four (4) day grace period included for all vaccine doses.

PRESCHOOL REQUIREMENTS

Written Documentation of :

Four (4) doses of D.P.T. or D.T.A.P. Vaccine.

Three (3) doses (3) of Polio Vaccine.

One (1) dose of H.I.B. after 12 months of age.

One (1) dose of M.M.R. after 12 months of age.

One (1) dose of Varivax administered after 12 months of age.

One (1) dose of PVC Pneumococcal Vaccine on or after the first birthday.

One (1) dose of Influenza Vaccine (annually).

KINDERGARTEN REQUIREMENTS

Written documentation of :

Four doses (4) of D.P.T. with one dose administered after the fourth birthday.

Three doses (3) of Polio with one dose administered after the fourth birthday or four doses appropriately spaced

Two (2) doses of M.M.R. administered after the first birthday.

Three doses of Hepatitis B vaccine administered at appropriate intervals.

One (1) dose of Varivax administered after 12 months of age or, laboratory, physician or parental documentation of disease.

6th GRADE REQUIREMENTS

Written documentation of :

MENINGOCOCCAL VACCINE - Every child born on or after January 1, 1997, when turning 11 yrs. old.

Tdap BOOSTER - Every child born on or after January 1, 1997.

STATE OF NEW JERSEY HEALTH HISTORY AND APPRAISAL

NAME OF CHILD (Last, First, MI)	DATE OF BIRTH (Mo./Day/Yr.)	SEX <input type="checkbox"/> M <input type="checkbox"/> F
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PARENT OR GUARDIAN	NAME	TELEPHONE NUMBER
	ADDRESS	NAME OF DOCTOR
	ADDRESS	DOCTOR'S TELEPHONE NO.

VACCINE TYPE	DISEASE MO/DAY/YR	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	MO/DAY/YR
DIPHTHERIA, TETANUS, PERTUSSIS (DTP) <small>(If Td, DtaP, or DT*, indicate in corner box)</small>	////// ////// //////						
POLIO-ORAL: POLIO VACCINE (OPV) <small>(If Salk Vaccine, indicate IPV in corner box)</small>	////// ////// //////						
MEASLES, MUMPS, RUBELLA (MMR)	//////				////////	////////	////////
MEASLES	////// //////				Measles Serology	DATE:	TITER:
RUBELLA	////// //////				Rubella Serology	DATE:	TITER:
MUMPS	////// //////				Mumps Serology	DATE:	TITER:
HAEMOPHILUS B (HIB)**	//////						
HEPATITIS B***							
OTHER, SPECIFY:							

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

DISEASE HISTORY	YEAR	YEAR	YEAR	OPERATIONS OR INJURIES	YEAR
ALLERGIES		ASTHMA		OTITIS MEDIA	
DRUG SENSITIVITIES		CHICKEN POX		RHEUMATIC FEVER	
LYME DISEASE		CONVULSIVE DIS.		STREP INFECTIONS	
HEPATITIS		DIABETES		MONONUCLEOSIS	
NEUROMUSC. DIS.		HEART DISEASE		OTHER	
				CONGENITAL DEFECTS	

HEALTH SCREENING CODE: N = Normal; R = Referred; T = Under Treatment; C = See Comments

Grade/Age	/										
Date	/										
Height	/										
Weight	/										
Blood Pressure	/										
V I S I O N	With Glasses	R									
		L									
		BOTH									
	Without Glasses	R									
		L									
		BOTH									
Muscle Balance											

Color Perception	Date	Results								
H E A R I N G	Date									
	Sweep Check	R								
		L								
	Complete Pure Tone	R								
L										

SCOLIOSIS SCREENING (Beginning at Age 10)

TB Screening (Mantoux Text)	Date	Date	Date	Chest X-Ray	Date	Normal	Abnormal	Therapy Case <input type="checkbox"/>	Reactor <input type="checkbox"/>
Tested	_____	_____	_____	_____	_____	_____	_____	Date Started	_____
Read	_____	_____	_____	_____	_____	_____	_____	Date Completed	_____
Result (MM)	_____	_____	_____	_____	_____	_____	_____		

*REQUIRES MEDICAL EXEMPTION **REQUIRED FOR DAY/CHILD CARE ENROLLEES (2 Months-5th Birthday Only) ***NOT REQUIRED (For Recording Purposes Only)