

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. <input type="checkbox"/> Yes <input type="checkbox"/> No	

Date of Physical Examination:	Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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	<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due:
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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 HEALTH HISTORY AND APPRAISAL

IMMUNIZATION REGISTRY NUMBER

Name of Child (Last, First, M.I.)		Date of Birth (Mo/Day/Yr)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
PARENT OR GUARDIAN	NAME	TELEPHONE NO.	
	ADDRESS		

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	
						Test Date	Result
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination <i>(If Td or DT, indicate in corner box)</i>							
Tdap							
POLIO – INACTIVATED POLIO VACCINE (IPV) <i>If oral vaccine, indicate (OPV) in corner box</i>							
MEASLES, MUMPS, RUBELLA (MMR)						Document below single antigen vaccine receipt, serology titers, or varicella disease history	
HAEMOPHILUS B (HIB)**							
HEPATITIS B						Hepatitis B	Date: _____ Titer: _____
VARICELLA						Varicella	Date: _____ Titer: _____
PNEUMOCOCCAL CONJUGATE **						Measles	Date: _____ Titer: _____
MENINGOCOCCAL						Mumps	Date: _____ Titer: _____
HEPATITIS A ***						Rubella	Date: _____ Titer: _____
HPV (HUMAN PAPILLOMAVIRUS) ***							
OTHER							

Provisional admission attached—Date Granted: _____
 Medical exemption attached
 Religious exemption attached

Proof of Immunization

Children without proof of age-appropriate immunizations will not be allowed to attend school. Parents must provide a record of up to date immunizations. New Jersey law requires the following:

- Children must have 4 doses of D.P.T.
- Children must have 3 doses of Polio vaccine
- Children must have 1 MMR vaccine given after the first birthday
- Children must have HIB vaccine according to schedule.
- Children must have Chicken Pox (Varicella) vaccine or documentation of Chicken Pox illness.
 - Children must have pneumococcal vaccine (Prevmar)
 - Flu shot(s) will be required between October 1st and December 15th

Please call the nurse @ 973- 509-4500 ext. 19 if you have any questions concerning health records or immunizations.