UNIVERSAL
CHILD HEALTH RECORD – PRESCHOOL ONLY

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

TO BE COMPLETED BY PARENT — SECTION I

Child's Name (Last)	(First)	(MI)	Gender	Date of Birth
			☐ Male ☐ Female	/ /

Does child Have Health Insurance?	If Yes, Name of Child's Health Insurance Carrier
☐ Yes ☐ No	

Parent / Guardian's Name	Home Telephone Number	Work Telephone or Cell Phone Number
Parent / Guardian's Name	**Home Telephone Number**	**Work Telephone or Cell Phone Number**

I give consent for my child's Health Care Provider / School Nurse to discuss the information on this form.

Signature/ Date This form may be released to WIC	☐ Yes ☐ No

TO BE COMPLETED BY HEALTH CARE PROVIDER — SECTION II

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 of 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 all necessary for daily activities items:*	☐ 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 or 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's Stamp:
Signature/ Date	

CH-14 OCT 06 Distribution: Original-Child Care Provider Copy- Parent/Guardian Copy-Health Care Provider

(Form # 6a)