ALLENDALE PUBLIC SCHOOLS

Endorsed by: American Academy of Pediatrics, New Jersey Chapter New Jersey Academy of Family Physicians

UNIVERSAL CHILD HEALTH RECORD *New Jersey Department of Health and Senior Services*

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last) (First)*	Gender Male 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.

Parent Signature	Date

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? Yes No

Abnormalities Noted:	Weight	
	Height	
	Blood Pressure	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due:

☐ Provisional Admission Attached – Date Granted: ______ Medical Exemption Attached ______ Religious Exemption Attached ______

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	Results
Hgb/Hct			**Hearing**		Right Left
Lead: Capillary Venous			**Vision**		Right Left
TB (mm of 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 Stamp:
Signature	Date	

CH-14 SEP 08 Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

Student: ________________________________ Date of Birth: _________________

IMMUNIZATION HISTORY

Please print clearly or attach a separate Immunization Report

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	Mo/Day/Yr
DIPTHERIA, TETANUS, PERTUSSIS *(If Td or DT, indicate in box)	/ /	/ /	/ /	/ /	/ /	/ /
POLIO-INACTIVATED POLIO (If oral vaccine, indicate OPV in box)	/ /	/ /	/ /	/ /	/ /	/ /
MEASLES, MUMPS, RUBELLA (MMR)	/ /	/ /	/ /	History of Disease or Titer		
MEASLES	/ /	/ /	/ /			
RUBELLA	/ /	/ /	/ /			
MUMPS	/ /	/ /	/ /	Hepatitis B	Date:	Titer:
HAEMOPHILUS B (HIB)**	/ /	/ /	/ /	Varicella	Date:	Titer:
HEPATITIS B	/ /	/ /	/ /	Measles	Date:	Titer:
VARICELLA	/ /	/ /	/ /	Mumps	Date:	Titer:
PNEUMOCOCCAL CONJUGATE**	/ /	/ /	/ /	Rubella	Date:	Titer:
MENINGOCOCCAL	/ /	/ /	/ /	/ /		
HEPATITIS A***	/ /	/ /	/ /	/ /		
HPV*** (HUMAN PAPILLOMAVIRUS)	/ /	/ /	/ /	/ /		
OTHER	/ /	/ /	/ /	/ /		

*REQUIRES MEDICAL EXEMPTION **REQUIRED FOR DAY/CHILD CARE ENROLLEES (2 months-5birthday only) ***NOT REQUIRED

Physician (Print or Stamp) Physician Signature