

1062
Complete both
sides

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)		Date of Birth / /			
Parent/Guardian Name (Mother)		Home Telephone Number		Work Telephone/Cell Phone Number	
Parent/Guardian Name (Father)		Home Telephone Number		Work Telephone/Cell Phone Number	
<i>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss my child's health concerns.</i>					
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		<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> 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 modifications:		<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)					
Signature/Date					

To be completed by parent

Operations or Accidents _____

Behavior (Please list any habits which may assist the health officer in meeting your child's needs) _____

FAMILY HISTORY

	Name	Year of Birth	State of Health
Father	_____	_____	_____
Mother	_____	_____	_____
Brother(s)	_____	_____	_____
	_____	_____	_____
Sister(s)	_____	_____	_____
	_____	_____	_____

Has any relation had:

Significant Allergy	Yes _____	No _____	Relation _____
Rheumatic Fever	Yes _____	No _____	Relation _____
Heart Disease	Yes _____	No _____	Relation _____
Diabetes	Yes _____	No _____	Relation _____
Tuberculosis	Yes _____	No _____	Relation _____
Convulsive Disorder	Yes _____	No _____	Relation _____
Mental Illness	Yes _____	No _____	Relation _____
Cancer	Yes _____	No _____	Relation _____
Other	_____	_____	Relation _____