CURIOUS CHILDREN
CHILD CARE CENTER

UNIVERSAL CHILD HEALTH RECORD

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

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name _____ (Last / First)	Gender: ☐ M ☐ F	Date of Birth: _____
Parent/Guardian Name: _____	Home Telephone Number _____	Work Telephone/Cell Phone _____
Parent/Guardian Name _____	Home Telephone Number _____	Work Telephone/Cell Phone _____

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. ☐ Yes ☐ No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

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 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

MEDICAL CONDITIONS cont'd…		
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	Note if Abnormal
Hgb/Hct			Hearing		
Lead: Capillary Venous			Vision		
TB (mm of Indurations)			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:** _____	