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 give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss my child's health concerns.

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
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 modifications:	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 Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

Name of Health Care Provider (Print)
Signature/Date