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 ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier	
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.

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

Condition		Comments
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	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
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	

 Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

Please attach Immunization Record

SAINT AMBROSE SCHOOL

Student Health History

Today's Date: ______________________
Child's Name: ______________________
____
Age: ______________________
Date of Birth: ______________________

Parent's Names ______________________
Address: ______________________
Phone: ______________________
Physician: ______________________
Phone: ______________________

A. Family History

1. Are the child's parents both in good health? Yes _____ No _____
   If no, please describe ______________________
   ____
2. List ages, sex, and general health of brothers and sisters: ______________________
   ____
   ____
3. Are there any significant family or mental problems? ______________________
   ____
   ____
4. Do any family members have a history of:

Diabetes _____
Heart Disease _____
Convulsions _____
Sickle Cell Trait _____
Tuberculosis _____
Asthma _____
Migraine _____
High Blood Pressure _____
Hepatitis _____
Sickle Cell Disease _____

B. Sleep Pattern:

1. How many hours of sleep does your child get each night? _____
2. Does your child have difficulty falling asleep? _____
3. Does your child have any of the following: (please circle)

Insomnia　　Sleepwalking　　Wakefulness during the night

C. Feeding and digestion:

Is the child's appetite usually good? Yes _____ No _____
Do any foods disagree with him/her? Yes _____ No _____
Does he/she often have diarrhea? Yes _____ No _____
Does he/she have frequent stomachaches? Yes _____ No _____

D. Infections & Illnesses: (Has you child had):

1. Frequent earaches? Yes _____ No _____
2. Frequent sore throats? Yes _____ No _____
3. Frequent colds? Yes _____ No _____
4. Urinary infections or related problems? Yes _____ No _____
5. High fever? Yes _____ No _____
6. Convulsions? Yes _____ No _____
7. Problems with vision? Yes _____ No _____

8. Problems with hearing? Yes _____ No _____
9. Wheezing or asthma? Yes _____ No _____
10. Eczema or hives? Yes _____ No _____
11. Dental problems? Yes _____ No _____
12. Allergic reaction to bee sting? Yes _____ No _____
13. Frequent nose bleeds? Yes _____ No _____
*14. Allergies or reaction to medication? Yes _____ No _____
Describe the allergies or reactions:
____
____

15. Circle any of the following which the child has had, and indicate in the blank at what age:

_____Chicken Pox _____Mumps _____Broken Bones
_____Measles _____Roseola _____Lyme Disease
_____German Measles _____Pneumonia _____Other
_____Sickle Cell Disease _____Sickle Cell Trait

E. Hospitalization? (Indicate reason & year)
1. Illness____
2. Surgery____

F. Last School attended (if any) ____
Address____

G. Is your child now taking medication? Yes _____ No _____
If yes, please explain: ____
____

H. Behavior
1. Does the child exhibit any of the following? (please circle)

Nail Biting Nightmares Breath Holding
Bed Wetting Speech Problems Fearful

2. Have you had any difficulty with your child? _______________ If so, describe problem and age that the child's difficulty was first noticed?
____
____
____

I. Is there any other information which would be helpful in understanding your child better thus enabling him/her to benefit fully from school experiences? _____________
____
____

SAINT AMBROSE SCHOOL
81 THROCKMORTON LANE
OLD BRIDGE, NJ 08857

DENTAL EXAMINATION FORM

______________________________ Name

______________________________ Date

I have examined the above named child.

_____ 1. There is no need for corrective work at this time.

_____ 2. Treatment has been completed.

_____ 3. There is need for dental care. An appointment has been scheduled: YES NO

____
Dentist's Signature

____
Address

____
Phone Number