

# UNIVERSAL CHILD HEALTH RECORD

*Endorsed by: American Academy of Pediatrics, New Jersey Chapter  
New Jersey Academy of Family Physicians  
New Jersey Department of Health and Senior Services*

SECTION I - TO BE COMPLETED BY PARENT(S)						
Child's Name (Last) _____ (First) _____		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth /      /		
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____		
<b>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</b>						
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)	_____	
<b>IMMUNIZATIONS</b>		<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 specifications:		<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		
<input type="checkbox"/> <b>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.</b>						
Name of Health Care Provider (Print) _____				Health Care Provider Stamp: _____		
Signature/Date _____						

## Instructions for Completing the Universal Child Health Record (CH-14)

### Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

### Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
  - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
  - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
  - **Head Circumference** - Only enter if the child is less than 2 years.
  - **Blood Pressure** - Only enter if the child is 3 years or older.
2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health and Senior Services, Immunization Program at 609-588-7512.
  - The Immunization record must be attached for the form to be valid.
  - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.
3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.
  - a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at [www.state.nj.us/health/forms/ch-15.dot](http://www.state.nj.us/health/forms/ch-15.dot) or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.
  - b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.  
  
PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration.

*Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

- c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.
  - d. **Special Equipment** - Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.
  - e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at [www.pacnj.org](http://www.pacnj.org) or by phone at 908-687-9340.
  - f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.
  - g. **Behavioral/Mental Health issues** - Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.
  - h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.
4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public health personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
    - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
    - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
    - Scoliosis screenings are done biennially in the public schools beginning at age 10.

This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.
  5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
    - Print the health care provider's name.
    - Stamp with health care site's name, address and phone number.

The Child Development Centers at Bristol-Myers Squibb  
Medication Administration Authorization

Dear Physician:

Please indicate the medications you authorize for \_\_\_\_\_ . If the event that any medication is needed at the Child Development Center, parents will also authorize medication administration. No medication will be dispensed without prior physician and parent authorization.

- Acetaminophen (Tylenol/Tempra) \_\_\_\_\_ cc/tsp/mg per 4 hours prn
- Benadryl/diphenhydramine \_\_\_\_\_ tsp/mg per 4-6 hours prn
- Dimetapp/Dimetapp DM \_\_\_\_\_ tsp per 6 hours prn
- (infant decongestant drops) \_\_\_\_\_ dropper(s) per 6 hours prn
- Ibuprofen (Motrin/Advil) \_\_\_\_\_ tsp/mg per 6 hours prn
- Mylicon \_\_\_\_\_ dropper(s) prn
- Orajel \_\_\_\_\_ apply to gums prn
- Pedicare (infant-decongestant) \_\_\_\_\_ dropper(s) per 4-6 hours prn
- (infant-decongestant/cough) \_\_\_\_\_ dropper(s) per 4-6 hours prn
- Robtussin/DM/CF \_\_\_\_\_ tsp per 4-6 hours prn
- Triaminic \_\_\_\_\_ tsp per 6 hours prn
- \_\_\_\_\_ tsp/mg \_\_\_\_\_ times/day prn
- \_\_\_\_\_ tsp/mg \_\_\_\_\_ times/day prn
- \_\_\_\_\_ tsp/mg \_\_\_\_\_ times/day prn
- Albuterol (via nebulizer) \_\_\_\_\_ amp/ml \_\_\_\_\_ times/day
- Cromolyn (via nebulizer) \_\_\_\_\_ cc/ns
- Bacitacin Ointment(s): \_\_\_\_\_ apply to skin prn
- Prn cuts, scrapes \_\_\_\_\_
- Other: \_\_\_\_\_ tsp/mg/gtts \_\_\_\_\_ times/day prn
- Other: \_\_\_\_\_ tsp/mg/gtts \_\_\_\_\_ times/day prn
- Other: \_\_\_\_\_ tsp/mg/gtts \_\_\_\_\_ times/day prn

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Physician's Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_