

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

Child's Name (Last)	(First)	Date of Birth
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. DYes DNa
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Date of Physical Examination: _____ Results of physical examination normal? Yes No

Abnormalities Noted:	Weight (must be taken within 30 days for WIG)	
	Height (must be taken within 30 days for WIG)	
	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:	DNone DSpecial Care Plan Attached	Comments
Medications/Treatments List medications/treatments:	DNone DSpecial Care Plan Attached	Comments
Limitations to Physical Activity List limitations/special considerations:	DNone DSpecial Care Plan Attached	Comments
Special Equipment Needs List items necessary for daily activities	DNone DSpecial Care Plan Attached	Comments
Allergies/Sensitivities List allergies:	DNone DSpecial Care Plan Attached	Comments
Special Diet/Witamin & Mineral Supplements List dietary specifications:	DNone DSpecial Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnoses List behavioral/mental health issues/concerns:	DNone OSpecial Care Plan Attached	Comments
Emergency Plans List emergency plan that might be needed and the Sign/symptoms to watch for:	DNone OSpecial Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Performed	Note if Abnormal
Hgb/Hct			Heating		
Lead: DCapillary DVenous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

Name of Health Care Provider (Print) _____ Health Care Provider Stamp _____

Signature/Date _____

MAKE SURE IMMUNIZATION SHEET IS ATTACHED!

NAME

Address

Birth Date

Father

Mother

Phone

Family Physician

Phone

PERSONAL HEALTH HISTORY Date recorded:

	No	Yes		No	Yes	Date
Illness of mother during pregnancy	0	0	Trouble with vision	0	0	
Birth Weight — lbs. — oz.			Frequent vomiting or diarrhea,	0	0	
Complications of delivery	0	0	Tendency to bleed easily	0	0	
Difficulty soon after birth	0	0	Eczema or hives	0	0	
Walked alone when _____ months old			Convulsions or other seizures	0	0	
Said a few words when _____ months old			Unusual nervousness, nail biting or thumb sucking	0	0	
Has child had:	No	Yes	Date			
Measles	0	0		Nightmares or trouble sleeping	0	0
Mumps	0	0		Breath-holding or temper tantrums	0	0
Rubella	0	0		Difficulty with toilet training or bed wetting	0	0
Chickenpox	0	0		Any severe injury	0	0
Rheumatic fever	0	0		Any operations	0	0
Asthma or wheezing	0	0				
Pneumonia or bronchitis	0	0				
Frequent sore throats	0	0				
Frequent ear infections	0	0				
Trouble with hearing	0	0				
Trouble with speech	0	0				

IMMUNIZATION

TUBERCULIN TESTS

Initial Series:	Boosters:	Date	Type	Reaction
Smallpox		1.		
DTP		2.		
DT		3.	"	
Oral Polio		4.		
Measles		5.	"	
Mumps		6.		
Rubella		7.		

FAMILY HEALTH HISTORY

Relation	Year of Birth	State of Health	Has any relation had:	No	Yes	Relation
Father			Significant allergy	0	<input type="checkbox"/>	
Mother			Rheumatic fever	0	0	
Brothers and Sisters			Fearful disease	0	0	
			Diabetes	0	0	
			Tuberculosis	0	0	
			Convulsive disorder	<input type="checkbox"/>	0	
			Mental illness	0	0	
			Cancer	0	0	

ADDITIONAL INFORMATION

TO BE COMPLETED BY PARENT.