

Physical Exam 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	
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. <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)		
IMMUNIZATIONS	<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 (as per state EPSDT requirements)					
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		
Heart (e.g. murmur):			Developmental		
Other:			Scoliosis		

I have examined the above student and reviewed his/her health history. Unless otherwise noted above, it is my opinion that s/he is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports.

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	