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

PARENT — DOCTOR

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

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	

Long Valley Christian Nursery Schoo
Phone: 908-876-4115
Fax: 908-876-4959

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

Long Valley Christian Nursery School
11 Schooley's Mountain Road
Long Valley, New Jersey 07853
(908)876-4115 Fax(908)876-4959

PRESCRIBED EMERGENCY MEDICATION PERMISSION FORM

MEDICATION MUST BE IN ORIGINAL CONTAINER

School Year: ____________________

Please have your doctor complete the information below concerning the emergency medication that your child must receive.
Please print all information legibly.

Child's Name ____

Name of Medication(s) ____________________________________

Prescription __________ Other in addition to prescription __________

Specific condition (name) for which medication is being used __________

Allergy(s) causing condition ______________________________

Conditions under which medication is to be administered __________

____

____

____

Instructions for administration, including the dosage and frequency of administration ____________________________________

____

____

____

Possible adverse reaction(s) ______________________________

____

Doctor's Signature ______________________________________

Doctor's Name(print) ____________________________________

Doctor's Telephone Number: _______________________________

I authorize LVCNS Faculty/Staff to administer the medication/treatment specified above for my child.

Parent's Signature and Date ______________________________

(Staff: Complete page two for record of administering medication)