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 ☐ 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	

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 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 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 heath 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.

Authorization for the Administration of
Over-The-Counter Medication by Camp *Chazak* Personnel

State law requires that there be written authorization for all medications, including over-the-counter medications and medicated ointments and creams. Other than any prescription medications specifically ordered and indicated on separate authorization for the administration of medication forms, only the medications listed below may be administered at camp by the Camp *Chazak* staff and are stocked in the camp health center.

Camper/Staff Name _____ _____ Date of Birth _____

The camp participant named herein may be administered the following by the Camp *Chazak* designees as approved by the standing orders of the camp physician advisor:

Check "Yes" to approve or "No" to disapprove of the administration of the specific medications listed below.

- ☐ Yes ☐ No Acetaminophen (dosage as indicated by age/weight) for minor discomfort
- ☐ Yes ☐ No Anti-itch gel or lotion to insect bite, poison ivy, oak, or sumac
- ☐ Yes ☐ No Antiseptic ointment to abrasions, scratches, cuts
- ☐ Yes ☐ No Ibuprofen (dosage as indicated by age/weight) for sore throat discomfort
- ☐ Yes ☐ No Pepto Bismol or Mylanta for upset stomach or nausea as directed
- ☐ Yes ☐ No Lotion or soothing ointment to sunburn
- ☐ Yes ☐ No Bug repellent

Note on the Administration of Medications at camp: Medications are administered at camp by staff trained in the methods of administration of medications shall be allowed to administer medications as prescribed by a camper's physician and as arranged with a camper's family to be administered at the camp.

AUTHORIZATION BY PHYSICIAN

I hereby authorize the camp personnel to administer the medications indicated above as ordered by my physician or approved by my physician and the camp physician advisor.

Physician's Name: _____

Signature: _____ Date _____

I hereby release and hold harmless the Camp *Chazak*, its agents, servants, and employees from any and all liability for injuries or other damage which may result to the student, his/her servants and representatives which may result from administration of the medication.

_____ _____

Parent/Guardian Signature Date

REQUEST FOR SELF ADMINISTRATION OF MEDICATION

(To be completed only if the child has a medical or allergy condition)

Camper's Name _____

Date of Birth _____

Asthma Inhalers _____ Insect Sting Kit _____

To Be Completed By Physician: (Please Print)

I am requesting that the above-named child be allowed to self-administer the following medications:

Name of Medication: _____

Diagnosis for which medication is given: _____

Prescribed dosage and time to be taken: _____

If Daily, at what time: _____

If "When needed", describe indications: _____

How soon can it be repeated: _____

Possible side effects and/or special precautions to be taken: _____

_____

Length of time this medication is prescribed: _____

Conditions under which self-administration will take place:

☐ Independently. Child has been trained and is proficient in self-administrating

☐ Under the supervision of camp trained designee.

Medication should be: ☐ stored in the designated area

☐ in the possession of student

_____ _____

Physician's Name (print) Physician's Signature

_____ _____

Telephone Number Date

To be completed By Parent: I give my permission for my child to self-administer the medication described above. I will notify the camp director if this medication is no longer required or self-administration is no longer directed by the physician.

The medication is to be provided by me in the original labeled container. To my knowledge my child is not allergic to this medication.

I hereby release and hold harmless the Camp *Chazak*, its agents, servants, and employees from any and all liability for injuries or other damage which may result to the student, his/her servants and representatives which may result from administration of the medication.

_____ _____

Parent/Guardian Signature Date