Catherine's COTTAGE DAYCARE

Universal Child Health Record

Endorsed by:
American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Last Name:	Child's First Name:	Gender: ◯ Male ◯ Female	DOB:

Parent's /Guardian Name:	Home Phone:	Work Phone/Cell Phone:
Parent's /Guardian Name:	Home Phone:	Work Phone/Cell Phone:

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 Exam:	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:

SECTION III - MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical conditions	☐ 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:

MEDICAL CONDITIONS (CONT'D)

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:

SECTION IV - 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 Indurations)			Dental		
Other:			Developmental		
Other:			Scoliosis		

I have examined the above student and review 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:	

Catherine's COTTAGE DAYCARE

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

SECTION I - PARENT(S)

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 II - 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 setting.
   a. If the child has a complex medical condition, a special care plan should be completed and attached. Note any significant medical conditions or major surgical history.
   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 likely 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 in durations 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.
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.