

The Gingham Giraffe Preschool 973-635-0033 Medical Form

Child's name _____ Birthdate _____

IMMUNIZATIONS REQUIRED BY LAW Month/Day/Year

DPT Series 1. _____ 2. _____ 3. _____ 4. _____ Booster _____ Booster _____

POLIO Series 1. _____ 2. _____ 3. _____ 4. _____ Booster _____ Booster _____

HIB Series 1. _____ 2. _____ 3. _____ 4. _____

HEPATITIS B 1. _____ 2. _____ 3. _____ 4. _____

MMR Series 1. _____ Booster _____

VARICELLA/VARIVAX 1. _____, 2. _____

PNEUMONIA 1. _____ 2. _____ 3. _____ 4. _____

INFLUENZA _____ **Due by December 31, 2018**

Please complete this portion.

Is there any reason this child cannot participate in the normal physical activities found in a Preschool program? _____. If yes, please explain

Is this child currently receiving any therapy? If yes, what type and how frequently? _____

Has the child had any of the following illnesses/conditions? If so, when?

ASTHMA ? _____ DIABETES ? _____ ALLERGIES/Foods? _____
Chicken pox _____ Rheumatic Fever _____ Seizures/convulsions _____
Measles _____ Heart Disease _____ Pneumonia _____

Is this child taking any kind of medication on a regular basis? _____

Does any condition warrant any kind of medication to be on the Preschool premises? _____

This child was given a routine medical exam and found to be free of infectious or contagious diseases.

Signature of Physician Address

I give the Preschool permission to directly contact the above Physician and/or his Staff to clarify any of the above information. PARENT SIGNATURE _____ DATE _____



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 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					
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		
Other:			Developmental		
Other:			Scoliosis		
<input type="checkbox"/> 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) _____					
Signature/Date _____					

