Health Form 2024-25

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 31,2024**

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 ☐ 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)
Signature/Date