

Roxbury Day Care Center, Inc.
 25 Righter Road
 Succasunna, NJ 07876

Phone: (973) 584-3
 Fax: (973) 252-4

UNIVERSAL CHILD HEALTH RECORD

American Academy of Pediatrics
 New Jersey Chapter

Endorsed by :
 New Jersey Department of
 Health & Senior Services

New Jersey Academy of
 Family Physicians

SECTION I - TO BE COMPLETED BY PARENT(S)					
Child's Name (Last)		(First)		Date of Birth	
Parent/Guardian Name (Mother)			Home Telephone Number		Work phone/Cell Phone Number
Parent/Guardian Name (Father)			Home Telephone Number		Work phone/Cell Phone Number
<i>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss my child's health concerns.</i>					
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		Comments	
Medications/Treatments List medications/treatments:		None	Special	Comments	
Limitations to Physical Activity List limitations/special considerations		None	Special	Comments	
Special Equipment Needs List items necessary for daily activities		None	Special	Comments	
Allergies/Sensitivities List Allergies		None	Special	Comments	
Special Diet/Vitamin & Mineral Supplements List Dietary modifications		None	Special	Comments	
Behavioral Issues/Mental Health Diagnosis List behavioral/mental health issues/concerns		None	Special	Comments	
Emergency Plans List emergency plan that might be needed and the signs/symptoms to watch for:		None	Special	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		
Name of Health Care Provider (Print)				Signature/Date	