

# 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 _____	
<b><i>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i></b>					
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) _____	
<b>IMMUNIZATIONS</b>		<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____			
<b>MEDICAL CONDITIONS</b>					
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 _____	
<b>PREVENTIVE HEALTH SCREENINGS</b>					
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"/> <b><i>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.</i></b>					
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, Vaccine Preventable Diseases Program at 609-826-4860.

- 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.nj.gov/health/forms/ch-15.dot](http://www.nj.gov/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](http://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 health 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.

## CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS

-To be completed by a Health Care Provider-

					Today's Date
Child's Full Name					Date of Birth
Parent's/Guardian's Name					Telephone No. (     )
Primary Health Care Provider					Telephone No. (     )
Specialty Provider					Telephone No. (     )
Specialty Provider					Telephone No. (     )
Diagnosis(es)					
Allergies					
<b>ROUTINE CARE</b>					
<b>Medication To Be Given at Child Care</b>	<b>Schedule/Dose (When and How Much?)</b>	<b>Route (How?)</b>	<b>Reason Prescribed</b>	<b>Possible Side Effects</b>	
List medications given at home:					
<b>NEEDED ACCOMMODATION(S)</b>					
Describe any needed accommodation(s) the child needs in daily activities and why:					
Diet or Feeding: _____					
Classroom Activities: _____					
Naptime/Sleeping: _____					
Toileting: _____					
Outdoor or Field Trips: _____					
Transportation: _____					
Other: _____					
Additional comments: _____					
_____					

**CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS**  
**Continued**

<b>SPECIAL EQUIPMENT / MEDICAL SUPPLIES</b>	
1. _____	
2. _____	
3. _____	
<b>EMERGENCY CARE</b>	
<b>CALL PARENTS/GUARDIANS</b> if the following symptoms are present: _____ _____	
<b>CALL 911 (EMERGENCY MEDICAL SERVICES)</b> if the following symptoms are present, as well as contacting the parents/guardians: _____ _____	
<b>TAKE THESE MEASURES</b> while waiting for parents or medical help to arrive: _____ _____ _____	
<b>SUGGESTED SPECIAL TRAINING FOR STAFF</b>	
_____ _____ _____	
Health Care Provider Signature	Date

<b>PARENT NOTES (OPTIONAL)</b>	
_____ _____ _____	
<i>I hereby give consent for my child's health care provider or specialist to communicate with my child's child care provider or school nurse to discuss any of the information contained in this care plan.</i>	
Parent/Guardian Signature	Date

**Important:** *In order to ensure the health and safety of your child, it is vital that any person involved in the care of your child be aware of your child's special health needs, medication your child is taking, or needs in case of a health care emergency, and the specific actions to take regarding your child's special health needs.*

## **Instructions for Completing the Care Plan for Children with Special Health Needs (CH-15)**

This Care Plan template is designed to supplement the Universal Child Health Record (UCHR, CH-14). It should be used for children with special health needs (CSHN). The UCHR is designed to be concise and does not provide sufficient space for detailed instructions that a CSHN might need. Use this Care Plan when your instructions for the child's care cannot be fit on to the UCHR. This Care Plan should be utilized as a template that can be adapted as needed. Not all parts need to be completed for some children, but other children may require extra pages to be attached to fully explain the instructions for the child's care.

In order to facilitate communication between the health care provider and the parent, it may be best to complete this form with the parent/guardian present. Parents often have practical knowledge that is important to incorporate into the plan, such as techniques to get the child to cooperate with treatments and specifics about the child care site/school like the hours attended and the resources/limitations of the out-of-home care provider. There is room at the end for optional parent notes and signature that will give permission for communication between the health care provider and the child care provider or school nurse.

### **Specific Instructions:**

1. Complete the Universal Child Health Record (UCHR, CH-14).
2. Attach a copy of immunization record.
3. As appropriate check off the box labeled "Special Care Plan Attached."
4. Complete the Care Plan for Children with Special Health Needs
  - Complete the demographic information.
  - The Primary Health Care Provider is the medical home where the child's complete health records are maintained.
  - Specialty providers and their contact information should be included if the specialists play a major role in the child's health care such as adjusting medication doses.
  - Diagnosis – Include major diagnoses (preferably using lay terminology as necessary).
  - Allergies – Include medication allergies and other significant environmental allergies.
  - Routine Care – Complete the medication information. Include important side effects that child care providers should be watching for both with medications administered at home as well as those given at child care.
  - Describe any Needed Accommodations to particular activities.
    - Describe special diets or feeding techniques which may be needed such as feeding pureed foods, maintaining upright positioning during feeds, following a restrictive diet, etc.
    - Classroom activities – List any modifications needed to allow the child to participate such as extra rest breaks, use of adaptive equipment, etc.
    - Outdoor Activities/Field Trips- List any special precautions needed for class trips such as emergency kits, mobile phones, special vehicles, etc.
  - Special Equipment/ Medical Supplies
    - List special equipment that may be needed such as nebulizers, peak flow meters, glucometers, braces, hearing aids, wheelchairs, apnea monitors, etc.
  - Emergency Care
    - Help the child care providers to understand which signs/symptoms merit calling the parents and which are more serious and indicate that EMS should be activated.
    - Describe interim measures that should be taken while waiting for parent or EMS arrival such as administering an asthma nebulizer treatment or an Epi-Pen.
  - Special Staff Training
    - Are there special trainings that staff should attend in order to care for the child such as medication administration training, first aid/CPR, etc.? Include who might be available to provide such training.