APPENDIX H

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

Condition		
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)	Health Care Provider Stamp:
Signature/Date	

 Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

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 <u>that is being used to complete the form</u>. 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 <u>www.nj.gov/health/forms/ch-15.dot</u> 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 <u>should</u> 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 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 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.

MT OLIVE TOWNSHIP PUBLIC SCHOOLS
School Health Services
Kindergarten Vision Examination Form

The Mt. Olive Township Board of Education recommends that all pre-school children have a complete eye examination before entering school in the fall. Good vision is essential to success in school.

Upon completion of the eye examination, have the examiner indicate his/her findings and recommendations on the form below. This form should be returned to the school nurse.

Student Name:_______________________________ Exam Date:_____________

I have given a complete eye exam with the following diagnosis and recommendations:

		Distance	Near		Distance	Near
Vision without correction	O.D.			O.S.		
Vision with correction	O.D.			O.S.		

Muscle Balance ________________________ **Color Test** ________________

Stereopsis ________________________

Eye Defects ____

Recommendations/Conclusions: Please circle or indicate other

1. **Normal eye examination**
2. **Corrective lens prescribed: YES NO**
3. **Re-examination recommendation: __________ (Date of return visit)**
4. **Other:____**

   (preferential seating, etc.)

Form Completion Date: _______________ Practitioner Signature: _______________

Please PRINT: Name of Physician________________________________
(or stamp)
Address________________________________

Phone________________________________

CSK/KvisionExam/010506

MT. OLIVE TOWNSHIP SCHOOLS
DENTAL EXAMINATION FOR SCHOOL ENTRANCE

I have been consulted concerning the dental condition of:

Pupil's Name: ____

Address: ____

School: ____

Please Check:

1. The necessary dental services have been completed: ___________
2. The pupil is receiving dental treatment: ____________________
3. The pupil at this time does not need dental treatment: __________
4. The pupil has had fluoride: ______________________________

____
Signature of Dentist

____
Date

Mt. Olive Township Public Schools
Student Annual Medical Update

Student Name: ____ DOB:_________

School:_____________ Grade/Teacher:_________________ School Year:____________

Concerns	Yes	No	Complete- If Yes
Allergic to: Bee Stings			Epi-Pen Yes No
Allergic to: Medications			List:
Allergic to: Foods			List Food and reaction: Epi-Pen Yes No
Any medications taken at home (dose, times)?			
Asthma			Medications:
Seasonal Allergies			Medications:
Attention Deficit			Medications: Hyperactivity: Yes No
Headaches			Medications:
Migraines			Medications: Symptoms:
Stomach Problems			
Constipation			
Hearing Problems			Hearing Aids: Yes No
Visual conditions			Glasses: Yes No Last Eye Exam:_____
Diabetes			Pump: Yes No
Cardiac/Heart conditions			Medications:
Seizures:			Medications: Date of last seizure
Behavior/emotional concerns			
Other General health/ medical concerns (eating/ sleep habits, posture, teeth, skin, menstruation, weight)			

THIS FROM HAS TWO SIDES PLEASE TURN OVER

Mt. Olive Township Public Schools
Student Annual Medical Update

SCHOOL HEALTH ROUTINES AND SCREENINGS

- **Cough drops, Tylenol, Motrin, and all medications (this includes over the counter and prescription medications except those listed below) require a physician's order to be administered in school. Please see Health Office website, and download forms if you wish your child to have any medication in school.**
- Height, weight and blood pressure, and hearing screenings are conducted on all student's pre-school through 5th grade as mandated by NJ State Law.
- Vision screening is conducted on all kindergarten, 2nd and 4th grade students who have not submitted a private physician's examination.
- If your child is in the 5th grade, scoliosis is required by NJ State law. If you would like your child to be excluded from this screening, please sign here: ________________________________. Copies of private physician examinations for scoliosis are due by June, 2021.
- **Please note that additional immunizations of Tdap and Meningococcal vaccine will be required for entrance to 6th grade.**

PERMISSIONS:

Do you give permission to share the aforementioned information with appropriate faculty and staff who work directly with your child? This information will be handled confidentially. YES NO (circle)

Health Care Practitioners/Specialists Information:

Practitioner Name	Practitioner Phone Number

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the person(s) named as emergency contacts, and do authorize the named physicians to render such treatment as may be deemed in an emergency, for the health of said child. In the event that physicians, emergency contacts, or parents/guardians cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Student Name: ____

Parent/Guardian Signature:_________________________Date:_____________