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

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	

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 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 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.

Stock Medication

Student Name:_____ Birth Date: _____Teacher:_____

Dear Parent/Guardian,

As a courtesy to our families, we will now stock the following medications at school:

1. Children's Benadryl: (liquid) Order Attached ☐

Diphenhydramine HCL 12.5/5ml oral solution antihistamine (Cherry flavored-**Not Dye Free)**

2. Chrildren's Advil: (liquid suspension) Order Attached ☐

Ibuprofen Fever Reducer/Pain Reliever (NSAID) 100mg per 5ml (Grape or Cherry-Berry Flavored)

3. Children's Tylenol: (liquid suspension) Order Attached ☐

Acetaminophen Pain Reliever-Fever Reducer 160mg per 5ml (Grape or Cherry Flavored)

4. Advil: (Tablets or Liqui-Gels) Order Attached ☐

Ibuprofen Pain Reliever/Fever Reducer (NSAID) 200mg

5. Tylenol: (Tablets) Order Attached ☐

Acetaminophen Pain Reliever- Fever Reducer 325mg

If your pediatrician prescribes these medications for your child, you are no longer required to send a supply of these medications to school unless your child requires dye free Benadryl, or Advil/Tylenol in chewable form or in a flavor preferred by your child.

Kindly return this form so that the nurse can administer the above mentioned stock medications to your child, provided the school has a completed order from your doctor.

I _____, give my child _____,

(Parent/Guardian Name Printed) (Students Name Printed)

permission for the above mentioned stock medications to be administered to my child by the school nurse.

I understand that a current doctor's order must be kept on file at the school for the current ESY/RSY School Year.

Parent/Guardian Signature: _____ Date: _____

MEDICATION CONSENT FORM

If during the school year it is necessary for your child to receive medication while he/she is at school, you will need to adhere to the regulations outlined below.

- If your child is to receive ANY medication during the school day your child's physician must complete the form below. This includes:
  - All prescription medications, (for example: Ritalin, Clonidine, Tegretol, EpiPen, etc.)
  - Any asthma medications, including inhalers and nebulizers.
  - Any medications required for a brief period of time, such as antibiotics, allergy medication, etc.
  - **Any over-the-counter medications** to be given on an as needed basis throughout the school year, such as Tylenol, Advil, Benadryl, cough medicine, eye drops, etc.
- All medication must be sent to the school **in the original container** with the appropriate label attached. **If the medication is not properly labeled it will NOT be given.**
- The parent/guardian **and physician** must sign this form, granting the school nurse permission to administer medication to the child during the school day.

Absolutely NO medication will be given if this form is not completed.

Student's Name: _____ Birth Date: _____
I hereby request that the following medication be administered by the school nurse, to the student named above.

Name of Medication: _____ Dosage: _____mg_____

Time/Circumstances of administration_____

Diagnosis/Purpose: _____

Length of treatment: From _____ To _____

Possible Side Effects _____

Special Instructions _____

In the event that the morning dose of this medication is forgotten, may this dose be administered at school after verifying this with the parent? _____**Yes** _____ **No**

Please list the dose if it is different from that noted above_____

May medication be given later than the prescribed time in the event that the student is out on a field trip?

_____**Yes** _____ **No** Please list the latest time the prescribed dose can be given_____

Parent/Guardian – Please initial one of the following if applicable:
On days when the student is dismissed early, the medication due at 1:00p.m. or later will:
_____ Be administered at school prior to dismissal.
_____ Be administered by the parent/guardian at home.

_____ _____ _____
Physician's Signature Address Date

_____ _____
Parent/Guardian Signature Date

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- The parent/guardian **and physician** must sign this form, granting the school nurse permission to administer medication to the child during the school day.

Absolutely NO medication will be given if this form is not completed.

Student's Name: _____ Birth Date: _____
I hereby request that the following medication be administered by the school nurse, to the student named above.

Name of Medication: _____**ACETAMINOPHEN**_____ Dosage: _____mg_____

Time/Circumstances of administration_____

Diagnosis/Purpose: _____

Length of treatment: From _____ To _____

Possible Side Effects _____

Special Instructions _____

In the event that the morning dose of this medication is forgotten, may this dose be administered at school after verifying this with the parent? _____**Yes** _____ **No**

Please list the dose if it is different from that noted above_____

May medication be given later than the prescribed time in the event that the student is out on a field trip?

_____**Yes** _____ **No** Please list the latest time the prescribed dose can be given_____

Parent/Guardian – Please initial one of the following if applicable:
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  - Any asthma medications, including inhalers and nebulizers.
  - Any medications required for a brief period of time, such as antibiotics, allergy medication, etc.
  - **Any over-the-counter medications** to be given on an *as needed* basis throughout the school year, such as Tylenol, Advil, cough medicine, eye drops, etc.
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- The parent/guardian **and physician** must sign this form, granting the school nurse permission to administer medication to the child during the school day.

Absolutely NO medication will be given if this form is not completed.

Student's Name: _____ Birth Date: _____

I hereby request that the following medication be administered by the school nurse, to the student named above.

Name of Medication: _____**IBUPROFEN**_____ Dosage: _____mg_____

Time/Circumstances of administration_____

Diagnosis/Purpose: _____

Length of treatment: From _____ To _____

Possible Side Effects _____

Special Instructions _____

In the event that the morning dose of this medication is forgotten, may this dose be administered at school after verifying this with the parent? _____**Yes** _____ **No**

Please list the dose if it is different from that noted above_____

May medication be given later than the prescribed time in the event that the student is out on a field trip?

_____**Yes** _____ **No** Please list the latest time the prescribed dose can be given_____

Parent/Guardian – Please initial one of the following if applicable:
On days when the student is dismissed early, the medication due at 1:00p.m. or later will:
_____ Be administered at school prior to dismissal.
_____ Be administered by the parent/guardian at home.

_____ _____ _____
Physician's Signature Address Date

_____ _____
Parent/Guardian Signature Date

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- The parent/guardian **and physician** must sign this form, granting the school nurse permission to administer medication to the child during the school day.

Absolutely NO medication will be given if this form is not completed.

Student's Name: _____ Birth Date: _____

I hereby request that the following medication be administered by the school nurse, to the student named above.

Name of Medication: _____**BENADRYL**_____ Dosage: _____mg_____

Time/Circumstances of administration_____

Diagnosis/Purpose: _____

Length of treatment: From _____ To _____

Possible Side Effects _____

Special Instructions _____

In the event that the morning dose of this medication is forgotten, may this dose be administered at school after verifying this with the parent? _____**Yes** _____ **No**

Please list the dose if it is different from that noted above_____

May medication be given later than the prescribed time in the event that the student is out on a field trip?

_____**Yes** _____ **No** Please list the latest time the prescribed dose can be given_____

Parent/Guardian – Please initial one of the following if applicable:
On days where the student is dismissed early, the medication due at 1:00p.m. or later will:
_____ Be administered at school prior to dismissal.
_____ Be administered by the parent/guardian at home.

_____ _____ _____
Physician's Signature Address Date

_____ _____
Parent/Guardian Signature Date