### UNIVERSAL CHILD HEALTH RECORD

**Child's Name (Last) (First)**

**Gender**
- Male
- Female

**Date of Birth**

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**Does Child Have Health Insurance?**
- Yes
- No

If Yes, Name of Child's Health Insurance Carrier

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**Parent/Guardian Name**

**Home Telephone Number**

**Work Telephone/Cell Phone Number**

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**Parent/Guardian Name**

**Home Telephone Number**

**Work Telephone/Cell Phone Number**

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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

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**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)

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### 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

**Medications/Treatments**
- List medications/treatments:
  - None
  - Special Care Plan Attached

**Limitations to Physical Activity**
- List limitations/special considerations:
  - None
  - Special Care Plan Attached

**Special Equipment Needs**
- List items necessary for daily activities:
  - None
  - Special Care Plan Attached

**Allergies/Sensitivities**
- List allergies:
  - None
  - Special Care Plan Attached

**Special Diet/Vitamin & Mineral Supplements**
- List dietary specifications:
  - None
  - Special Care Plan Attached

**Behavioral Issues/Mental Health Diagnosis**
- List behavioral/mental health issues/concerns:
  - None
  - Special Care Plan Attached

**Emergency Plans**
- List emergency plan that might be needed and the sign/symptoms to watch for:
  - None
  - Special Care Plan Attached

### PREVENTIVE HEALTH SCREENINGS

<table>
<thead>
<tr>
<th>Type Screening</th>
<th>Date Performed</th>
<th>Record Value</th>
<th>Type Screening</th>
<th>Date Performed</th>
<th>Note if Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hgb/Hct</td>
<td></td>
<td></td>
<td>Vision</td>
<td></td>
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</tr>
<tr>
<td>Lead</td>
<td>Capillary</td>
<td></td>
<td>Dental</td>
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<td></td>
<td>Venous</td>
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<tr>
<td>TB (mm of induration)</td>
<td></td>
<td></td>
<td>Developmental</td>
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<td></td>
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<tr>
<td>Other:</td>
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<td></td>
<td>Scoliosis</td>
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</tbody>
</table>

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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:**

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**Signature/Date:**

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**CH-14 SEP 08**

**Distribution: Original-Child Care Provider**

**Copy-Parent/Guardian**

**Copy-Health Care Provider**

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**PLEASE ATTACH YOUR CHILD'S IMMUNIZATION RECORD**