New Jersey Department of Health and Senior Services
STANDARD SCHOOL / CHILD CARE CENTER IMMUNIZATION RECORD

NAME OF CHILD (Last, First, MI)	DATE OF BIRTH (Mo./Day/Yr.)	SEX ☐M ☐F
NAME OF PARENT/GUARDIAN	TELEPHONE NUMBER(S)	
ADDRESS		
ADDRESS	IMMUNIZAITON REGISTRY NUMBER	

VACCINE TYPE	1ST DOSE MO/DAY/YR	2ND DOSE MO/DAY/YR	3RD DOSE MO/DAY/YR	4TH DOSE MO/DAY/YR	5TH DOSE MO/DAY/YR	LEAD SCREENING *(Not Required)*	
						TEST DATE	RESULT
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT[1], indicate in corner box)							
POLIO-INACTIVATED POLIO VACCINE (IPV) (If oral vaccine, indicate OPV in corner box)							
MEASLES, MUMPS, RUBELLA (MMR)							
HAEMOPHILUS B (HIB) [2]							
HEPATITIS B [3]							
VARICELLA [4]							
PNEUMOCOCCAL CONJUGATE [2]							
INFLUENZA [5]							
OTHER, SPECIFY:							

☐Provisional Admission Attached - Date Granted: _____ ☐Medical Exemption Attached ☐Religious Exemption Attached

[1] REQUIRES MEDICAL EXEMPTION.
[2] REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (2 Months - 5th Birthday Only)
[3] REQUIRED FOR K-GRADE 1 (whichever is first). GRADE 6 BEGINNING 9-1-01, AND GRADES 9-12, EFFECTIVE 9-1-04.
[4] REQUIRED FOR DAY/CHILD CARE ENROLLEES (19 Months and older) AND GRADE K-GRADE 1 (whichever is first) EFFECTIVE 9-1-04.
[5] MMR single antigen receipt requires MO/DAY/YR, serologies require titers, and varicella disease history requires MO/YR.
[6] REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (6 Months – 59 Months)

UNIVERSAL CHILD HEALTH RECORD

Endorsed by:
American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health and Senior Services

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		

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	