New Jersey Department of Health and Senior Services

		STANDARD SCI	HOOL / CHILD	CARE CENTER	IMMUNIZAT	ION RECORD				
NAME OF CHILD (Last, F	irot, MI)	•	-	•	-	DATE OF BIRTH (Mo	SEX DM DF			
NAME OF PARENT/GUA	RDIAN					TELEPHONE NUMBE	ER(S)	4		
ADDRESS	na an ini ini ini ini ini ini ini ini in	4	-	-	5					
ADDRESS					IMMUNIZATON REGISTRY NUMBER					
VACCINE TYPE		1ST DOSE 2ND DOSE MO/DAY/YR MO/DAY/YR		3RD DOSE MO/DAY/YR	4TH DOSE MO/DAY/YI			SCREENING t Required)		
DIPHTHERIA, TETANUS, (DTaP) or any combinatio (If Td or DT <sup>(1)</sup> , indicate in t	n comer box)						TEST DATE	RESULT		
OLIO-INACTIVATED PC ACCINE (IPV) If oral vaccine, indicate Ol										
MEASLES, MUMPS, RUE	BELLA (MMR)									
HAEMOPHILUS B (HIB)	2)	-								
EPATITIS B (3)		-								
ARECELLA (9)			-	,	ne ogen van de Englise in een kaar naar oor een een					
PNEUMOCOCCAL CONJ	IUGATE <sup>(2)</sup>		-		-		-			
NFLUENZA (6)		-		•						
DTHER, SPECIFY:				•						
Provision	nal Admission Attack	ned - Date Granted:	,	[]Medi	cal Exemption /	Attached EReligi	ous Exemption At	lached -		
MA1-8 MAR 08	<sup>(2)</sup> REQUIRED FOR <sup>(3)</sup> REQUIRED FOR <sup>(4)</sup> REQUIRED FOR	R DAY/CHILD CARE P	ver is first). GRADE ( NROLLEES (19-Mor	5 BEGINNING 9-1-01,	AND GRADES	9-12, EFFECTIVE 9-1-04 E 1 (whichever is first) Ef history requires MO/VR.	FECTIVE 9-1-04.	J0012		

MAR 08

## 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

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Child's Name (Last)			(Firs	States of the local division of the local di		Gende	a substitution of the subs	WHER BUT AND	D	ate of Bi	rth		
							lale	🗌 Fema	le		1	1	
Does Child Have Health Insura	nce? If Y	es Nam	e of C	bild's He	alth In	suranc	e Carri	ier			-		ngan gan da da da sa
Does Child Have Health Insurance? If Yes, Name of Child's Health Insurance Carrier													
Parent/Guardian Name	I	Pary and the basic states and the basic states in the basic states and the basic states are the basic states and	THe	nme Telen	hone	lumber	r	lanı və dinimar tirəndi	Work	Telenho	nel()	ell Phone	Number
				Home Telephone Number Work Telephone/C						1000	GAT HOLIO		
Parent/Guardian Name			Home Telephone			ne Number			Work Telephone/Cell Phone Number				
	÷												
I give my concent for my chi	no Provid	er and Child Care Provider/School Nurse to discuss the informatio						tion on th	ic form				
Signature/Date	0.0110000000000	10110110	G1 6316			10001/0							
Juginalurer Dale							This form may be released to WIC.						
	2. (-) (•). (•). (•	122 (3) -	200	Teard.	1.14	73 (A)	Tel T	1 .		Cattored		S. Maria	
Date of Physical Examination:	Sall in	Results of physical examination normal?     Pyes     No											
Abnormalities Noted:	and the second second second	ennen sinn mene	Thesuits	or priy	SILCIEA								
Apromantes Noted.	Abnormalities Noted:						Weight(must be taken within 30 days for WIC)						
							Height (must be taken						
						within 30 day			and the subclick Playson	2	entrutete eta		and the second secon
							Head Circumference (if <2 Years)						
							Blood Pressure					90	
		1					(if <u>&gt;</u> 3	Years)					
IMMUNIZATIONS			Immunization Record										
		L]Da		t Immuniz		Action to						میں در استخدی میں میں است (اور 19 مار اس	
Chronic Medical Conditions/Relat	od Surgoriae			DICAL CO				nako kata na ka	adaliliyan Maadalaa		andungala della		and the state of the
<ul> <li>List medical conditions/neial</li> </ul>						Comments							
concerns:	-99	Att	Attached										
Medications/Treatments		a percent	None			ments							
List medications/treatments:			Special Care Plan Attached										
Limitations to Physical Activity	altern (sprach nachastala), anny altaitean				Com	ments			inangia andi sistemba			The second states of the	
Limitations to Physical Activity     List limitations/special considerations:			Special Care Plan Attached										
					Com	ments						A	
Special Equipment Needs			Special Care Plan										
<ul> <li>List items necessary for daily</li> </ul>	acuvilles	Att	ached					contractor in and	Alatorius maat indonesiasi		Constantin Bran		
Allergies/Sensitivities				Care Plan	Com	ments							
List allergies:			ached										
Special Diet/Vitamin & Mineral Su	oplements	No			Com	ments		in any provincian of the second	-				
List dietary specifications:			Special Care Plan Attached										
Behavioral Issues/Mental Health Diagnosis			ne	and the second	Com	ments		a di sa kana di sa kana sa kan Kana sa kana sa					
List behavioral/mental health			Special Care Plan										
issues/concerns: Emergency Plans			Attached			Comments							
List emergency plan that might be needed			Special Care Plan										
and the sign/symptoms to wa	tch for:	the second s	ached	and the second se		ter forsen and the figure	man de porto		all the second second second		-		
				VE HEAL	TH SC								
Type Screening	Date Perfor	med	Reco	ord Value		the second design of the secon	Screen	ing	Date F	Performe		Note if A	bnormal
Hgb/Hct						earing			البرجور الإيتينيوه اوراب				
Lead: Capillary Venous TB (mm of Induration)						Vision Dental					<u> </u>	na na hanna ann an tarainn an tara	
Other:					Developmental								
Other:						Scoliosis							
Name of Health Care Provider (Pr		Northing Courses and		-	Care Pi		Stamp:	ini ana ang ang ang ang ang ang ang ang ang			ng li den egya kili (ji teksen nase		
Signature/Date	n ta a chun ta ann an Arbain a Mhairtean a												