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.

NJ Department of Health (NJDOH)
Vaccine Preventable Disease Program

Summary of NJ Child Care/Preschool Immunization Requirements

Listed in the chart below are the minimum required number of doses your child must have to attend a NJ child care/preschool.* This is strictly a summary document. Exceptions to these requirements (i.e. provisional admission, grace periods, and exemptions) are specified in the Immunization of Pupils in School rules, New Jersey Administrative Code (N.J.A.C. 8:57-4). Please reference the administrative rules for more details https://www.nj.gov/health/cd/imm_requirements/acode/. Additional vaccines are recommended by Advisory Committee on Immunization Practices (ACIP) for optimal protection. For the complete ACIP Recommended Immunization Schedule, please visit http://www.cdc.gov/vaccines/schedules/index.html.

At this age the child should have received the following vaccines:	**2 months**	**4 months**	**6 months**	**12 months**	**15 months**	**18 months**	**19 months**	**20-59 months**
Diphtheria, tetanus & acellular pertussis (DTaP)	Dose #1	Dose #2	Dose #3			Dose #4		
Inactivated Poliovirus (Polio)	Dose #1	Dose #2				Dose#3		
Haemophilus influenzae type b (Hib)	Dose #1	Dose #2		1-4 doses† (see footnote)	.	At least 1 dose given on or after the first birthday		
Pneumococcal conjugate (PCV 13)	Dose #1	Dose #2		1-4 doses† (see footnote)	At least 1 dose given on or after the first birthday			
Measles, mumps, rubella (MMR)					Dose #1‡			
Varicella (VAR)							Dose #1 §	
Influenza (IIV; LAIV)			One dose due each year‖					

***Interpretation:** **Children need to receive the minimum number of age-appropriate vaccines prior to entering child care/preschool. For example, a child 2 months of age, must have 1 dose each of DTaP, Polio, Hib, and PCV before being permitted to enter child care/preschool. A child entering at a younger age range than listed above must have proof of receiving vaccines in the previous age bracket. Example: A child entering child care/preschool at 11 months of age, would need at least the following: 3 DTaP, 2 Polio, 2 Hib, and 2 PCV. If a child has not received any vaccines, he/she would need at least one dose of each required vaccine to enter school provisionally and be in the process of receiving the remaining doses as rapidly and as medically feasible. The current seasonal flu vaccine is required every year by December 31 for children 6-59 months of age.**

†***Haemophilus influenzae* type b (Hib) and pneumococcal (PCV)** vaccines are special cases. If children started late with these vaccines they may need fewer doses. One dose of each is required on or after the first birthday in all cases.

Please Note: The use of combination vaccines may allow students to receive the 1st birthday booster dose of Hib between 15-18 months of age.

‡**MMR vaccine may be given as early as 12 months of age**, but NJ requires children to receive the vaccine by 15 months of age. Prior to age 15 months, children may enter preschool/child care without a documented dose of MMR.

§**Varicella vaccine may be given as early as 12 months of age**, but NJ requires children to receive the vaccine by 19 months of age. Prior to age 19 months, children may enter preschool/child care without a documented dose of varicella. Children who previously had chickenpox do not need to receive the varicella vaccine as long as a parent/guardian can provide the school with one of the following: 1) Documented laboratory evidence showing immunity (protection) from chickenpox, 2) A physician's written statement that the child previously had chickenpox, or 3) A parent's written statement that the child previously had chickenpox.

|**Seasonal Flu:** The current seasonal influenza vaccine is required every year for those children 6 months through 59 months of age. Children who have not received the flu vaccine by December 31 must be excluded (not allowed to attend child care/preschool) for the duration of influenza season (through March 31), until they receive at least one dose of the influenza vaccine or until they turn 60 months of age. Children entering child care/preschool after December 31, must provide documentation of receiving the current seasonal flu vaccine. Children entering child care/preschool after March 31 are not required to receive the flu vaccine; however, flu season may extend until May and therefore getting a flu vaccine even late in the season is still protective.

NOTE: NJ also accepts valid medical and religious exemptions (reasons for not showing proof of immunizations) as per the NJ Immunization of Pupils in School regulations, (N.J.A.C. 8:57-4). Children without proof of immunity as defined by ACIP, including those with medical and religious exemptions, may be excluded from a school, preschool, or child care facility during a vaccine preventable disease outbreak or threatened outbreak as determined by the Commissioner, Department of Health or his or her designee. In addition, anybody having control of a school may, on account of the prevalence of any communicable disease, or to prevent the spread of communicable disease, prohibit the attendance of any teacher or pupil of any school under their control and specify the time during which the teacher or scholar shall remain away from school. The Department of Health shall provide guidance to the school of the appropriateness of any such prohibition.

This document is meant to be a quick resource. For more information "NJ Immunization Requirements Frequently Asked Questions", please visit https://nj.gov/health/cd/imm_requirements/.

Reviewed: 12/2021

***Interpretation:** **Children need to receive the minimum number of age-appropriate vaccines prior to entering child care/preschool. For example, a child 2 months of age, must have 1 dose each of DTaP, Polio, Hib, and PCV before being permitted to enter child care/preschool. A child entering at a younger age range than listed above must have proof of receiving vaccines in the previous age bracket. Example: A child entering child care/preschool at 11 months of age, would need at least the following: 3 DTaP, 2 Polio, 2 Hib, and 2 PCV. If a child has not received any vaccines, he/she would need at least one dose of each required vaccine to enter school provisionally and be in the process of receiving the remaining doses as rapidly and as medically feasible. The current seasonal flu vaccine is required every year by December 31 for children 6-59 months of age.**

This information is provided to you by the

New Jersey Department of Health
Vaccine Preventable Disease Program
609-826-4861

For Additional Information:

New Jersey Department of Health **Communicable Disease Service** **http://nj.gov/health/cd/index.shtml**	**Centers for Disease Control and Prevention** **http://www.cdc.gov/vaccines/**
New Jersey Department of Health **Vaccine Preventable Disease Program** **https://www.nj.gov/health/cd/vpdp.shtml**	**ACIP Recommendations** **http://www.cdc.gov/vaccines/hcp/acip- recs/index.html**
New Jersey Vaccines for Children Program **https://njiis.nj.gov/core/web/index.html#/vfcDocs**	**Vaccine Package Inserts** **http://www.immunize.org/packageinserts/**
New Jersey Immunization Information System **https://njiis.nj.gov/njiis/**	**Vaccine Information Statements** **http://www.cdc.gov/vaccines/hcp/vis/index.html**
New Jersey Disease Reporting Requirements/Regulations: **http://nj.gov/health/cd/reporting/when/**	**Guide to Contraindications and Precautions to Commonly Used Vaccines** **http://www.immunize.org/catg.d/p3072A.pdf**
New Jersey School Health **https://www.nj.gov/health/cd/topics/schoolhealth.shtml**	**Vaccine Adverse Event Reporting System** **http://vaers.hhs.gov/index**
New Jersey COVID-19 Vaccine Page **https://www.state.nj.us/health/cd/topics/covid2019_vaccination.shtml**	**New Jersey COVID-19 Information Hub** **https://covid19.nj.gov/**

ST. THERESE SCHOOL Nurse's Office

135 Main Street, Succasunna NJ 07876
Tel: 973-584-0812 Fax: 973-584-2029

Request For Medication Administration

In accordance with New Jersey State Law 6A: 16-2.l(a)2, St Therese School policy states that ***school nurses only or the principal*** (if the nurse is unavailable) are able to administer medications to the students. *This is to be done only if medication has been prescribed by the child's physician who has noted diagnosis, medication, dosage and time. This includes any over-the-counter medications. In addition, parent/guardian must sign permission form below and return to the school nurse. The permission form MUST be updated every school year.

Prescriptions must be in properly labeled pharmacy containers: over-the-counter medications must be in the original container and accompanied by a physician's note provide by the parents/guardians. Medication should be brought to school by the end of the first week of school and picked up by the last day of school by a designated adult. All medications sent to school will be locked in the nurse's office.

I understand that the St. Therese School and its employees or agents shall have no liability as a result of any injury arising from the administration of the medication listed below; and shall indemnify and hold harmless the district and its employees or agents against any claims arising out of administration of the medication.

Students who require inhalers or epi-pens MUST HAVE unique forms on file with the office such as the Asthma Action Plan and/or Anaphylaxis Emergency form completed and signed by a physician as well.

Authorization is hereby given for medication to be administered in school to:

Student Name: _____Grade: _____

Diagnosis: _____

Medication: _____

Dosage: _____ Frequency: _____ Time to be administered: _____

In the event of school trips, student may skip medication dose for that day: YES_____ NO_____

*Physician's Signature: _____ Date: _____

Physician's Stamp Here:

Physician's Printed Name: Telephone:

Parent's Signature: _____Date: _____

Nurse's Signature: _____Date: _____