

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 <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth / /	
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No	
SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER					
Date of Physical Examination: _____			Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> 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		<input type="checkbox"/> Immunization Record Attached			
		<input type="checkbox"/> Date Next Immunization Due: _____			
MEDICAL CONDITIONS					
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Medications/Treatments • List medications/treatments:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Limitations to Physical Activity • List limitations/special considerations:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Equipment Needs • List items necessary for daily activities		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Allergies/Sensitivities • List allergies:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:		<input type="checkbox"/> None <input type="checkbox"/> 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: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		
Name of Health Care Provider (Print) _____			Health Care Provider Stamp:		
Signature/Date _____					

CAMP YACHAD 2010 AUTHORIZATION TO ADMINISTER MEDICATION TO CAMPERS

HEALTH CARE PROVIDER MUST SIGN FOR ALL MEDICATIONS

To better serve the needs of children, the JCC of Central NJ and Camp Yachad must have parental or legal guardian authorization to administer any and all medications, as well as a health care provider's signature and dosage information for all medications on file.

It is our policy that no medication (prescription or non-prescription) will be administered without an authorization form signed and dated by the parent/legal guardian and the health care provider. Please complete and return this form to the Camp Yachad office by **MAY 3.**

PLEASE SAVE A COPY FOR YOUR RECORDS!

Child's Name _____ Date of Birth _____ Age _____
Dentist _____ Address _____ Phone _____ FAX _____

EMERGENCY CONTACT INFORMATION (OTHER THAN PARENT/LEGAL GUARDIAN)

Emergency Contact Name	Relationship	Home Number	Work Number	Cell Number	Authorized to Make Decisions? YES NO

PRESCRIPTION MEDICATION

Name of Medication	Indication	Dose	Frequency	Time(s) of Day	Permission to Administer (YES or NO)

OVER-THE-COUNTER MEDICATION

Name of Medication	Indication	Dose	Frequency	Time(s) of Day	Permission to Administer (YES or NO)
Acetaminophen/Tylenol	Headache, fever, pain				
Ibuprofen/Motrin/Advil or equivalent	Headache, fever, pain				
Robitussin or equivalent	Cough				
Benadryl	Allergy, itch				
Tums or equivalent	Heartburn				
Lactaid tablets or equivalent	Digestion of dairy				
Swim ear drops	Water in ear				
Dramamine or equivalent	Motion sickness				
Other (name):					

I do hereby give permission to the nursing/medical personnel selected by the JCC to secure and administer treatment, including first aid (i.e. Bacitracin and Neosporin ointments, Caladryl/Calamine lotion, hydrocortisone cream), x-rays, routine tests and hospitalization for the child named above.

Parent/Legal Guardian Signature _____ **Date** _____

Health Care Provider Signature _____ **Date** _____

Address _____ **Phone** _____ **FAX** _____

Mandatory for Campers