The Learning Tree Pre-School

"Helping Children Grow"

993 Green Street, Iselin, NJ 08830
(732) 283-4746

Medical History: (dates)

Whopping Cough	________	Otitis Media	________	Chicken Pox	________
Tonsillitis	________	(middle ear inflamn.)		Mumps	________
Diphtheria	________	Measles	________	Asthma	________
Scarlet Fever	________	German Measles	________	Diabetes	________
Paralysis	________	Pneumonia	________	Convulsions	________
Tuberculosis	________	Rheumatic Fever	________		

Immunization Record:

DtaP: 1. ______ 2. ______ 3. ______ Booster: 1. ______ 2. ______

IPV/OPV 1. ______ 2. ______ 3. ______ Booster: 1. ______ 2. ______

MMR: 1. ______ 2. ______ 3. ______ Varicella: 1. ______ 2. ______

Mantoux Test: ________ Results: ________ Other: ____________

HIB 1. ______ 2. ______ 3. ______ 4. ________ ____________

Hepatitis B 1. ______ 2. ______ 3. ______

Prevnar (recommended): 1. ______ 2. ______ 3. ______ 4. ______

Physical Examination By Physician:

Height	______	Teeth/Gums	______	Lungs	______	Orthopedic	______
Weight	______	Throat	______	Abdomen	______	Nutrition	______
Eyes	______	Skin	______	Hernia	______	Nervous System	______
Ears	______	Glands	______	Genitals	______		
Nose	______	Heart	______	Speech	______		

In view of my physical examination, I believe the applicant to be physically and mentally developed within normal limits. He/She may participate in all activities of a childcare center.

Physician's Full Name: ______________________________

Physician's Signature: ______________________________

Physician's Address: ______________________________

Physician's Telephone Number(s): ______________________________

Date of Examination: ______________

UNIVERSAL CHILD HEALTH RECORD

American Academy of Pediatrics
New Jersey Chapter

Endorsed by:
New Jersey Department of
Health and Senior Services

New Jersey Academy of
Family Physicians

Child's Name *(Last)*	*(First)*	Date of Birth / /
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

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: ☐Capilary ☐Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

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