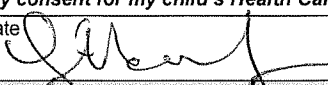
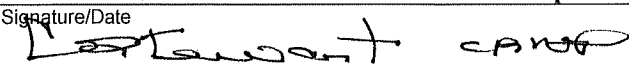


UNIVERSAL CHILD HEALTH RECORD

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) Alkanat		Child's Name (First) Ela		Gender ☐ Male ☒ Female	Date of Birth 12 / 19 / 2009
Does Child Have Health Insurance? ☒ Yes ☐ No		If Yes, Name of Child's Health Insurance Carrier BCBS of Alabama (valid until 9.30.2017)			
Parent/Guardian Name Gokhan Alkanat		Home Telephone Number 334-669 0371		Work Telephone/Cell Phone Number 334-669 0371	
Parent/Guardian Name Gulso C. Alkanat		Home Telephone Number 334-669 0371		Work Telephone/Cell Phone Number 334 669 0371	
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  9.1.2017				This form may be released to WIC. ☒ Yes ☐ No	
SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER					
Date of Physical Examination: 9-5-17		Results of physical examination normal? ☒ Yes ☐ No			
Abnormalities Noted:		Weight (must be taken within 30 days for WIC)		48.4	
		Height (must be taken within 30 days for WIC)		48.3"	
		Head Circumference (if <2 Years)			
		Blood Pressure (if ≥3 Years)		94/62	
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 Allergies - environmental	
Medications/Treatments • List medications/treatments:		☐ None ☐ Special Care Plan Attached		Comments Claritin 5mg	
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 Nuts, Nutella, Fruits	
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	9-5-17	
Lead: ☐ Capillary ☒ Venous			Vision		
TB (mm of Induration)			Dental	#14-5-17	Ø
Other:			Developmental	9-5-17	Ø
Other:			Scoliosis	9-5-17	Ø
☒ 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) Carol M. Stewart			Health Care Provider Stamp:		
Signature/Date  9.1.2017					

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 health 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.

**HADDONFIELD PUBLIC SCHOOL
HADDONFIELD, NEW JERSEY
CONFIDENTIAL HEALTH HISTORY
Preschool Through 5th Grade Students**

Child's Name Ela Alkanat Sex M ☒ F Date of Birth 12-19-2009
Country of birth: USA Was this child adopted? yes ☒ no
Parent'/Guardian' Names Gokhan Alkanat Address 279 Lake Street, Haddonfield, NJ
Phone Number 384-6690371 Blood Type (if known) _____
Physician _____ Phone Number _____

I. Pregnancy & Birth (Check One)

1. Did the mother have any illness during pregnancy with this child? _____ Yes ☒ No
2. Did the mother deliver on her due date? _____ Yes ☒ No
If not, explain 5-week premature
3. Did the mother have any difficulty during delivery? _____ Yes ☒ No
If yes, explain _____
4. Did your child have any difficulty during or after delivery? _____ Yes ☒ No
If yes, explain _____
5. Did your child have any trouble starting to breathe? _____ Yes ☒ No
6. Did your child have any trouble in the hospital? _____ Yes ☒ No
If yes, explain _____
7. What did your child weigh at birth? 5 Lbs. 0 Ozs.

II. Family/Social

1. Are both parents in good health? ☒ Yes _____ No
2. Are there any family members with serious health problems that we should be aware of? If so, please explain _____ Yes ☒ No

III. Development Milestones (Place Age)

- | | | | |
|----------------------|------------------|-------------------|----------------|
| 1. Sitting Alone | <u>5</u> months | 6. Dressed self | <u>4</u> years |
| 2. Crawled | <u>9</u> months | 7. Fed self | <u>4</u> years |
| 3. Walked alone | <u>12</u> months | 8. Ties shoes | <u>7</u> years |
| 4. Spoke first words | <u>12</u> months | 9. Toilet trained | <u>2</u> years |
| 5. Spoke sentences | <u>2</u> year | | |

IV. Traits

1. Does your child play with children other than brothers/sisters? ☒ Yes _____ No
2. Is your child: ☒ self-reliant _____ dependent?
3. Is your child: ☒ outgoing _____ shy?
4. Which hand does your child use for most tasks? ☒ Right _____ Left _____ Both
5. Are you concerned about any of the following (Check)

☐ Bad tempered	☐ Will not mind	☐ Trouble with friends
☐ Jealous	☐ Sleep problems	☐ Thumb sucking
☐ Nail biting	☐ Stuttering	☐ Understanding speech
☐ Aggressiveness	☐ Temper Tantrums	☐ Over-activity
☐ Poor Concentration	☐ Abnormal Movements	☐ Un-coordination

V. Medication

- Is the student on any type of medication at this time? _____ Yes ☒ No
If yes, please list medicine, dosage and reason for administration of same: _____

VI. Infections, Illnesses, and Other Problems

Has your child:

- | | | |
|---|---|--|
| 1. Had more than six (6) colds or throat infections each year? | ☐ Yes | ☒ No |
| 2. Had more than three (3) ear infections? | ☐ Yes | ☒ No |
| 3. Had trouble hearing? | ☐ Yes | ☒ No |
| 4. Had his/her hearing tested? | ☒ Yes | ☐ No |
| 5. Had any trouble seeing? | ☐ Yes | ☒ No |
| 6. Had his/her eyes tested? | ☒ Yes | ☐ No |
| 7. Had any trouble with his/her teeth? | ☐ Yes | ☒ No |
| 8. Seen a dentist recently? | ☒ Yes | ☐ No |
| 9. Had any trouble passing his/her urine? | ☐ Yes | ☒ No |
| 10. Check any of the following that your child has had and indicate year: | | |
| ☐ Strep Infection | ☐ Whooping Cough | ☐ Genetic Testing (explain below) |
| ☐ Chicken Pox | ☐ Headache | ☐ Brain Trauma |
| ☐ Measles | ☐ Vision Loss | ☐ Concussion |
| ☐ Rubella | ☐ Hearing Loss (Rt/Lt) | ☐ Lead Poisoning |
| ☐ Mumps | ☐ Speech Impediment | ☐ Bedwetting |
| ☐ Rheumatic Fever | ☐ Fainting | |
| ☐ Pneumonia | ☐ Seizures | |

Please explain any further details concerning the above checked areas, if needed: _____

11. Had other diseases: Please indicate year

If so, name them _____

Had to stay in the hospital overnight? _____

☐ Yes

☒ No

Age _____ Hospital _____

Reason _____

12. Had your child had any serious accidents? Operations?

☐ Yes

☒ No

If yes, explain _____

13. Has your child ever been evaluated by the Child Study Team?

☐ Yes

☒ No

VII. Allergies Check if applicable and indicate year

- | | | |
|-----------------------------------|--|--|
| ☐ Wheezing | ☐ Sinus trouble | ☐ Reaction to Insect _____ bite _____ sting |
| ☐ Eczema | ☐ Hay Fever | ☐ Reaction to medication |
| ☐ Asthma | ☐ Hives | Which medication: _____ |

VIII. Nutrition

Food allergies hazelnut, walnut, almond (Medicine: Claritin)

Food likes Grapes Food dislikes pork products

Appetite – good ☒ poor _____ snack eater _____

Unusual weight gain or weight loss no

IX. Summary

Is there anything in regard to your child's habits, health or behavior that you would like to comment upon? _____

X. Permission To Share Information:

I ☒ do ☐ do not give the school nurse permission to share medical information on a needs to know basis with appropriate school staff. Please note any exceptions: _____

PARENT'S/GUARDIAN'S SIGNATURE _____

DATE

9.1.2017

New/Transfer Student's Medical Requirements for Admission to The Haddonfield District Schools:

1. Must present proof of the following immunizations, in accordance with the New Jersey State Department of Health.
 - a. *Diphtheria and Tetanus Toxoids and Pertussis* (DTP) Vaccine:
A minimum of four (4) doses of DTP are required. One dose must have been **administered on or after the fourth birthday**. A child with any total of five valid doses of DTP, DTaP, DTP/Hib, or DT will also be in compliance with this regulation.
 - b. *Poliovirus* Vaccine:
A minimum of three (3) doses of either oral polio vaccine (OPV) or enhanced inactivated Poliovirus vaccine (IPV) is required, **provided at least one dose is given on or after the fourth birthday**. Alternatively, a child with any four (4) doses of polio vaccine spaced by a minimum of one month (28days) will also be in compliance with this requirement.
 - c. *Measles, Mumps, Rubella* (MMR) Vaccine:
 1. Measles vaccine – Two (2) doses of a measles-containing vaccine given **on or after the first birthday**, preferably MMR, will be required of children born on or after January 1, 1990. The two doses of measles-containing vaccine must be separated by an interval of at least one month.
 2. Mumps Vaccine – One dose of mumps vaccine administered **on or after the first birthday**.
 3. Rubella Vaccine (German Measles) – One dose **on or after the first birthday**.
 - d. *Hepatitis B* (Hep B) Vaccine:
 1. Children born on or after January 1, 1996 are required to receive three (3) doses of a hepatitis B vaccine.
 - e. *Varicella* Vaccine:
 1. One dose of varicella administered **on or after the first birthday**.
2. Students are required to have a **physical** completed using the Universal Child Health Record. This examination must be done **no more than 365 days prior to entry** and must state what, if any, modifications are required for full participation in the school program. The physical form **must be signed** by your child's **healthcare provider**. *(No office stamp or office staff initials will be accepted.)*
3. A completed Haddonfield District's **Confidential Health History** form for grades first through fifth and a **Medical Questionnaire** form for fourth & fifth grade students. Both forms are to be signed by parent/guardian.
4. **Out-of-Country** students *may be* required to supply the results of a **Mantoux Test (PPD)** for tuberculosis, performed within the past 6 months from the entry date.