Universal Health Form

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's name: _____ **Gender:** _____

Date of birth: _____ mm / dd / yyyy

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:** _____

Parent's consent - 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: _____ mm / dd / yyyy

This form may be released to WIC:

◯ Yes ◯ No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of examination: _____ mm / dd / yyyy

Results of physical examination normal?

◯ Yes ◯ No

Abnormalities noted:

Weight: _____ **Height:** _____

Head circumference: _____ **Blood pressure:** _____

Immunization

Check if applicable:

☐ Immunization record attached

☐ Date next immunization due

Date next immunization due: _____ mm / dd / yyyy

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

Hgb / hct - Date performed: _____ mm / dd / yyyy

Hgb / hct - Record value: _____

Lead - Check if applicable:

- [ ] Capillary
- [ ] Venous

Lead - Date performed: _____ mm / dd / yyyy

Lead - Record value: _____

TB (mm of induration) - Date performed: _____ mm / dd / yyyy

TB (mm of induration) - Record value: _____

Other type screening: _____

Other - Date performed: _____ mm / dd / yyyy

Other - Record value: _____

Other type screening: _____

Other - Date performed: _____ mm / dd / yyyy

Other - Record value: _____

Hearing - Date performed: _____ mm / dd / yyyy

Hearing - Note if abnormal: _____

Vision - Date performed: _____ mm / dd / yyyy

Vision - Note if abnormal: _____

Dental - Date performed: _____ mm / dd / yyyy

Dental - Note if abnormal: _____

Developmental - Date performed: _____ mm / dd / yyyy

Developmental - Note if abnormal: _____

Scoliosis - Date performed: _____ mm / dd / yyyy

Scoliosis - Note if abnormal: _____

Completion

- [ ] 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: _____

Signature:
Date: _____ mm / dd / yyyy