*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<br>☐ Date Next Immunization Due: _____ |
|---|---|

### MEDICAL CONDITIONS

| | | |
|---|---|---|
| Chronic Medical Conditions/Related Surgeries<br>• List medical conditions/ongoing surgical concerns: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Medications/Treatments<br>• List medications/treatments: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Limitations to Physical Activity<br>• List limitations/special considerations: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Special Equipment Needs<br>• List items necessary for daily activities | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Allergies/Sensitivities<br>• List allergies: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Special Diet/Vitamin & Mineral Supplements<br>• List dietary specifications: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Behavioral Issues/Mental Health Diagnosis<br>• List behavioral/mental health issues/concerns: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Emergency Plans<br>• List emergency plan that might be needed and the sign/symptoms to watch for: | ☐ None<br>☐ 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.

FOR SCHOOLS AND PARENTS: K-12 IMMUNIZATION REQUIREMENTS

**NJ Department of Health (NJDOH)**
**Vaccine Preventable Disease Program**

## Summary of NJ School Immunization Requirements

Listed in the chart below are the minimum required number of doses your child must have to attend a NJ school.* 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.

| *Grade/level child enters school:* | | **Minimum Number of Doses for Each Vaccine** | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | **DTaP Diphtheria, Tetanus, acellular Pertussis** | **Polio Inactivated Polio Vaccine (IPV)** | **MMR (Measles, Mumps, Rubella)** | **Varicella (Chickenpox)** | **Hepatitis B** | **Meningococcal** | **Tdap (Tetanus, diphtheria, acellular pertussis)** |
| **Kindergarten – 1st grade** | | A total of 4 doses with one of these doses on or after the 4th birthday OR any 5 doses† | A total of 3 doses with one of these doses given on or after the 4th birthday OR any 4 doses‡ | 2 doses§ | 1 dose‖ | 3 doses | None | None |
| **2nd – 5th grade** | | 3 doses *NOTE: Children 7 years of age and older, who have not been previously vaccinated with the primary DTaP series, should receive 3 doses of Td. For use of Tdap, see footnote.* † | 3 doses | 2 doses | 1 dose | 3 doses | None | See footnote† |
| **6th grade and higher** | | 3 doses | 3 doses | 2 doses | 1 dose | 3 doses | 1 dose required for children born on or after 1/1/97 given no earlier than ten years of age¶ | 1 dose required for children born on or after 1/1/97¶ |

* Children who did not receive any vaccines would need at least one dose of each required vaccine to enter school provisionally.

†**DTaP:** Children who previously attended child care/preschool should have received 4 doses since the requirement to receive the fourth birthday booster dose (5th dose) does not apply until they attend Kindergarten. However, if one of these 4 doses was given on or after the 4th birthday, an additional dose is not needed for Kindergarten. Alternatively, any 5 doses are acceptable.

Children seven years and older who are not fully immunized with DTaP vaccine should have a history of receiving at least three doses of DTaP, Td, and/or Tdap or should use the CDC Catch-Up schedule to get caught up. Tdap given at ages 10 and older can count towards the sixth-grade school requirement. For CDC schedules and catch-up guidance, visit https://www.cdc.gov/vaccines/schedules/hcp/imz/catchup.html.

‡**Polio**: Children who previously attended child care/preschool should have 3 doses since the requirement to receive the fourth birthday booster dose (4th dose) does not apply until they attend Kindergarten. However, if one of these 3 doses was given on or after the 4th birthday, no additional doses are needed for Kindergarten. Alternatively, any 4 doses are acceptable.

§**MMR:** Children are required to receive two doses of measles, one dose of mumps, and one dose of rubella once they enter Kindergarten. Since single antigen (separate components of the vaccine) is not readily available, most children will have two MMR vaccines.

The Antibody Titer Law (Holly's Law, NJSA 26:2N-8-11), passed on January 14, 2004, requires the New Jersey Department of Health (NJDOH) to accept serologic evidence of protective immunity to measles, mumps and rubella in lieu of the second ACIP recommended measles, mumps and rubella vaccine. For more information, please visit http://nj.gov/health/cd/documents/antibody_titer_law.pdf.

‖**Varicella** vaccine is only required for children born on or after January 1, 1998. 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.

¶**Meningococcal and Tdap** vaccines are required for all entering 6th graders who are 11 years of age or older. If in 6th grade and under age 11, children must receive the vaccines within 2 weeks of their 11th birthday. Meningococcal (MenACWY) vaccines administered at age 10 or older will be accepted for NJ school attendance. As of the 2020-2021 school year, children who receive a Tdap before age 10 would need to receive an additional dose to meet NJ's immunization requirements for sixth grade and higher. Note, ACIP no longer recommends a minimum interval between a dose of Tdap and a tetanus-diphtheria-containing vaccine, however, current rule [N.J.A.C. 8:57-4.10(i)] states a minimum of five years must have elapsed from the last tetanus-and diphtheria-containing dose.

**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/.**

Revised: 12/2021

**This information is provided to you by the**

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

## For Additional Information:

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

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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: _____