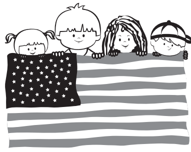

LOOKING GLASS CHILDREN'S CENTER

CHILD CARE CENTER IMMUNIZATION RECORD

NAME OF CHILD (Last, First, MI)	DATE OF BIRTH (MO/DAY/YR) SEX ☐ M ☐ F
NAME OF PARENT / GUARDIAN	TELEPHONE NUMBER(S)
ADDRESS	
ADDRESS	IMMUNIZATION REGISTRY NUMBER

VACCINE TYPE	1ST DOSE MO/DAY/YR	2ND DOSE MO/DAY/YR	3RD DOSE MO/DAY/YR	4TH DOSE MO/DAY/YR	5TH DOSE MO/DAY/YR	LEAD SCREENING (Not Required)	
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT(1), indicate in corner box)						TEST DATE	RESULT
POLIO-INACTIVATED POLIO VACCINE (IPV) (If oral vaccine, indicate OPV in corner box)							
MEASLES, MUMP2, RUBELLA (MMR)					(5) Document below single antigen vaccine receipt, serology titer, or Vericella disease history		
HAEMOPHILUS B (HIB) (2)							
HEPATITIS B (3)					Hepatitis B	DATE:	TITER:
VARICELLA (4)					Varicella	DATE:	TITER:
PNEUMOCOCCAL CONJUGATE (2)					Measles	DATE:	TITER:
INFLUENZA (6)					Mumps	DATE:	TITER:
OTHER, SPECIFY:					Rubella	DATE:	TITER:

☐ Provisional Admission Attached - Date Granted: ______________________ ☐ Medical Exemption Attached ☐ Religious Exemption Attached

PHYSICAL EXAMINATION:

General Observations: ____

____

____

____

Is there any reason the child cannot participate or should not participate in any or all age-appropriate school activities? ________________ If "Yes", please specific any restrictions:

____

____

____

____

I have examined the above-named child and have found the child to be physically fit to be admitted to Looking Glass Children's Center, and participate in all activities without risk either to the child or to the school.

Physician's Signature: ____________________________

Address: ____________________________

____

Phone: ____________________________

Date: ____________________________

UNIVERSAL CHILD HEALTH RECORD

ENDORSED BY:
NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES
AMERICAN ACADEMY OF PEDIATRICS NEW JERSEY CHAPTER
NEW JERSEY ACADEMY OF FAMILY PHYSICIANS

SECTION 1 - TO BE COMPLETED BY PARENT(S)

CHILD NAME: (LAST)	(FIRST)	DATE OF BIRTH: / /
DOES CHILD HAVE HEALTH INSURANCE? ☐ YES ☐ NO	IF YES, NAME THE CHILD'S HEALTH INSURANCE CARRIER	
PARENT/GUARDIAN NAME	HOME PHONE NUMBER	WORK NUMBER/ MOBILE NUMBER
PARENT/GUARDIAN NAME	HOME PHONE NUMBER	WORK NUMBER/ MOBILE 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 2 - TO BE COMPLETED BY HEALTH CARE PROVIDER

DATE OF PHYSICAL EXAMINATION:	RESULT 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 ☐ CAPILLARY ☐ VENOUS			VISION		
TB (mm OF INDURATION)			DENTAL		
OTHER:			DEVELOPMENTAL		
OTHER:			SCOLIOSIS		

NAME OF HEALTH CARE PROVIDER (PRINT)	HEALTH CARE PROVIDER STAMP:
SIGNATURE/DATE	