

American Academy of Pediatrics  
New Jersey Chapter

Endorsed by:  
New Jersey Department of  
Health and Senior Services

New Jersey Academy of  
Family Physicians

## SECTION 1: TO BE COMPLETED BY PARENT(S)

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
<b>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</b>		
Signature/Date _____		This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No

## SECTION 2: TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination: _____	Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> 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:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	<input type="checkbox"/> None <input type="checkbox"/> 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: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other			Scoliosis		

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