

# 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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	
<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 II - 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)		
<b>IMMUNIZATIONS</b>	<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> 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		

<input type="checkbox"/> <b>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.</b>	
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](http://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.

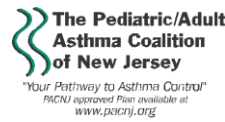
PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration.

*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](http://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.

# Asthma Treatment Plan – Student

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) (Physician's Orders)



(Please Print)

Name	Date of Birth	Effective Date
Doctor	Parent/Guardian (if applicable)	Emergency Contact
Phone	Phone	Phone

## HEALTHY (Green Zone)



You have **all** of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above \_\_\_\_\_

If exercise triggers your asthma, take \_\_\_\_\_ m puff(s) \_\_\_\_\_ minutes before exercise.

Take daily control medicine(s). Some inhalers may be more effective with a "spacer" – use if directed.

MEDICINE	HOW MUCH to take	and HOW OFTEN to take it
Advair® HFA	45, 115, 230	2 puffs twice a day
Aerospan™	1, 2	puffs twice a day
Alvesco®	80, 160	1, 2 puffs twice a day
Dulera®	100, 200	2 puffs twice a day
Flovent®	44, 110, 220	2 puffs twice a day
Qvar®	40, 80	1, 2 puffs twice a day
Symbicort®	80, 160	1, 2 puffs twice a day
Advair Diskus®	100, 250, 500	1 inhalation twice a day
Asmanex® Twisthaler®	110, 220	1, 2 inhalations once or twice a day
Flovent® Diskus®	50, 100, 250	1 inhalation twice a day
Pulmicort Flexhaler®	90, 180	1, 2 inhalations once or twice a day
Pulmicort Respules® (Budesonide)	0.25, 0.5, 1.0	1 unit nebulized once or twice a day
Singulair® (Montelukast)	4, 5, 10 mg	1 tablet daily
Other		
None		

Remember to rinse your mouth after taking inhaled medicine.

## Triggers

Check all items that trigger patient's asthma:

- Colds/flu
- Exercise
- Allergens
  - Dust Mites, dust, stuffed animals, carpet
  - Pollen - trees, grass, weeds
  - Mold
  - Pets - animal dander
  - Pests - rodents, cockroaches
- Odors (Irritants)
  - Cigarette smoke & second hand smoke
  - Perfumes, cleaning products, scented products
  - Smoke from burning wood, inside or outside
- Weather
  - Sudden temperature change
  - Extreme weather - hot and cold
  - Ozone alert days
- Foods:
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
- Other: \_\_\_\_\_

## CAUTION (Yellow Zone)



You have **any** of these:

- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other: \_\_\_\_\_

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from \_\_\_\_\_ to \_\_\_\_\_

Continue daily control medicine(s) and ADD quick-relief medicine(s).

MEDICINE	HOW MUCH to take	and HOW OFTEN to take it
Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2	puffs every 4 hours as needed
Xopenex®	2	puffs every 4 hours as needed
Albuterol	1.25, 2.5 mg	1 unit nebulized every 4 hours as needed
Duoneb®	1	unit nebulized every 4 hours as needed
Xopenex® (Levalbuterol)	0.31, 0.63, 1.25 mg	1 unit nebulized every 4 hours as needed
Combivent Respimat®	1	inhalation 4 times a day
Other		

Increase the dose of, or add:  
Other: \_\_\_\_\_

• If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.

## EMERGENCY (Red Zone)



Your asthma is getting worse fast:

- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue
- Other: \_\_\_\_\_

And/or Peak flow below \_\_\_\_\_

Take these medicines NOW and CALL 911. Asthma can be a life-threatening illness. Do not wait!

MEDICINE	HOW MUCH to take	and HOW OFTEN to take it
Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4	puffs every 20 minutes
Xopenex®	4	puffs every 20 minutes
Albuterol	1.25, 2.5 mg	1 unit nebulized every 20 minutes
Duoneb®	1	unit nebulized every 20 minutes
Xopenex® (Levalbuterol)	0.31, 0.63, 1.25 mg	1 unit nebulized every 20 minutes
Combivent Respimat®	1	inhalation 4 times a day
Other		

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

Disclaimers: The use of this Web-based Asthma Treatment Plan does not constitute an "as is" basis. The American Lung Association of the Mid-Atlantic (ALAMA), the Pediatric/Adult Asthma Coalition of New Jersey and all affiliates disclaim all warranties, express or implied, statutory or otherwise, including but not limited to the implied warranties or merchantability, non-infringement of third party rights, and fitness for a particular purpose. ALAMA makes no representation or warranty about the accuracy, reliability, completeness, currency or timeliness of the content. ALAMA makes no warranty, representation or guaranty that the information will be uninterrupted or error free or that any defects can be corrected. It is advised that ALAMA be liable for any damages (including, without limitation, incidental and consequential damages, personal injury/property loss, lost profits, or damages resulting from data or business information) resulting from the use or inability to use the content of this Asthma Treatment Plan whether based on warranty, contract, tort or any other legal theory, and whether or not ALAMA is advised of the possibility of such damages. ALAMA and its affiliates are not liable for any claims, damages, losses, or expenses, caused by your use or misuse of this Asthma Treatment Plan, any of its website. The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association in New Jersey. This publication was supported by a grant from the New Jersey Department of Health and Senior Services, with funds provided by the U.S. Centers for Disease Control and Prevention under Cooperative Agreement 5U49CE000474-01. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the New Jersey Department of Health and Senior Services or the U.S. Centers for Disease Control and Prevention. Although this document has been funded wholly or in part by the United States Government under Agreement 5U49CE000474-01, the U.S. Government and its agencies do not endorse, recommend, or approve the views or opinions expressed through the Agency's publication review process and therefore, they may not necessarily reflect the views of the Agency and no official endorsement should be inferred. Information in this publication is not intended to diagnose health problems or take the place of medical advice. For advice on any medical condition, seek medical advice from your child's or your health care professional.

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### Permission to Self-administer Medication:

This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.  
This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Physician's Orders

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

PHYSICIAN STAMP

Make a copy for parent and for physician file, send original to school nurse or child care provider.

# Asthma Treatment Plan – Student Parent Instructions



The PACNJ Asthma Treatment Plan is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

- 1. Parents/Guardians:** Before taking this form to your Health Care Provider, complete the top left section with:
  - Child's name
  - Child's doctor's name & phone number
  - Parent/Guardian's name & phone number
  - Child's date of birth
  - An Emergency Contact person's name & phone number
- 2. Your Health Care Provider will** complete the following areas:
  - The effective date of this plan
  - The medicine information for the Healthy, Caution and Emergency sections
  - Your Health Care Provider will check the box next to the medication and check how much and how often to take it
  - Your Health Care Provider may check **“OTHER” and:**
    - ✓ Write in asthma medications not listed on the form
    - ✓ Write in additional medications that will control your asthma
    - ✓ Write in generic medications in place of the name brand on the form
  - Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow
- 3. Parents/Guardians & Health Care Providers together** will discuss and then complete the following areas:
  - Child's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
  - Child's asthma triggers on the right side of the form
  - Permission to Self-administer Medication section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form
- 4. Parents/Guardians:** After completing the form with your Health Care Provider:
  - Make copies of the Asthma Treatment Plan and give the signed original to your child's school nurse or child care provider
  - Keep a copy easily available at home to help manage your child's asthma
  - Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

## PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

Parent/Guardian Signature \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

## FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.

**RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY**

I do request that my child be **ALLOWED** to carry the following medication \_\_\_\_\_ for self-administration in school pursuant to N.J.A.C.:6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

I **DO NOT** request that my child self-administer his/her asthma medication.

Parent/Guardian Signature \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

