

UNIVERSAL CHILD HEALTH RECORD

Endorsed by the Virgin Islands Department of Human Services

SECTION I - TO BE COMPLETED BY PARENT(S)/ GUARDIAN		
Child's Name (Last) (First)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Does the 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 or Cell Phone Number
Parent/ Guardian Name	Home Telephone Number	Work Telephone or Cell Phone Number
<i>I give consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss information on this form.</i>		
Signature/Date	This form may be released to the V.I. Department of Human Services <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 Height Weight	
Abnormalities Noted:		
IMMUNIZATIONS <input type="checkbox"/> Immunization Record Attached	<input type="checkbox"/> All recommended immunizations are up to date	<input type="checkbox"/> A catch-up schedule for immunizations has been initiated
MEDICAL CONDITIONS		
Chronic Medical Conditions/ Related Surgeries • List medical conditions and 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 needed 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 • List dietary specifications	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Behavioral Issues/ Mental Health Concerns • List behavioral/mental health issues	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the signs/symptoms to watch for:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
<i>θ I have examined the child listed above 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.</i>		
Name of Health Care Provider	Address of Health Care Provider	
Signature/Date	Phone Number of Health Care Provider	

Distribution: Original - Child Care Provider Yellow Copy - Parent/Guardian Pink Copy - Health Care Provider