Universal Child Health Record

Endorsed by the Virgin Islands Department of Human Services

CTION 1 TO BE COMPLETED BY PARENT{S) /GUARDIAN		
Child's Name (Last) (First)	Gender (O Male O Female	Date of Birth / /
Does the child have health insurance (O Yes O 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 give consent for my child's Health Care Provider & Child Care Provider/School Nurse to discuss information on this form.		
Signature / Date	his form may be release to the V.I. DeRartment of Human Services (O Yes O No	

SECTION 2 - TO BE COMPLETED BY HEALTH CARE PROVIDER

IMMUNIZATION ( ) Immunization Record Attached ( ) All recommended immunizations are up to date.

( ) A catch-up schedule for immunizations has been initiated

Vaccine	("}If Vaccine Series is Completed	If NOT Completed,Date of Next Dose Due
Dtap		
Hepatitis A		
Hepatitis B		
Hib		
Influenza		
MMR		
Polio		
Prevnar		
Rotavirus		
Varicella		

Date of PhysicalExamination: Results of physicalexamination normal? ( ) Yes ()No

Height: Weight:

Abnormalities Noted:

MEDICAL CONDITIONS		
Chronic MedicalConditions/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/specialconsiderations	( ) None ( ) Special Care Plan Attached	Comments:
SpecialEquipment Needs *List items needed for daily activities	( ) None ( ) Special Care Plan Attached	Comments:
Allergies/Sensitivities *List allergies	( ) None ( ) Special Care Plan Attached	Comments:
Special Diet *List dietary specifications	( ) None ( ) SpecialCare Plan Attached	Comments:
Behavioral Issues/Mental Health Concerns *List behavioral/mentalhealth issues	( ) None ( ) SpecialCare Plan Attached	Comments:
Emergency Plans *List emergency plan that might be need and the signs/symptoms to watch for:	( ) None ( ) SpecialCare Plan Attached	Comments:

( ) I have exammed the ch1ld hsted above & rev1ewed h1s/her health h1story. It IS my op1mon that he/she 1s med1cally cleared to participate fully in all child care/schoolactivities, including physical education & competitive contact sports, unless noted above.

A copy of the child's Immunization Record must be attached and the Physician completing this form must print and sign name below

Address of Health Care Provider	Phone Number of Health Care Provider
Physician Name: (Please Print)	Physician Name: (Signature) Date:

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