Good Shepherd Children's Center

3139 County Road 516

Old Bridge, New Jersey

732-679-8887

The child's immunization records must be obtained from your child's physician.

New Jersey Department of Health
STANDARD SCHOOL / 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
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT[1], indicate in corner box)					
POLIO-INACTIVATED POLIO VACCINE (IPV) (If oral vaccine, indicate OPV in corner box)					
MEASLES, MUMPS, RUBELLA (MMR)					
HAEMOPHILUS B (HIB)					
HEPATITIS B (HepB)					
VARICELLA					
PNEUMOCOCCAL CONJUGATE (PCV13)					
INFLUENZA					
OTHER, SPECIFY:					
OTHER, SPECIFY:					
OTHER, SPECIFY:					

LEAD SCREENING *(Not Required)*	
TEST DATE	RESULT

[5] Document below single antigen vaccine receipt, serology titers, or varicella disease history

Hepatitis B	DATE:	TITER:
Varicella	DATE:	TITER:
Measles	DATE:	TITER:
Mumps	DATE:	TITER:
Rubella	DATE:	TITER:

Exemptions:
☐ Medical Exemption Attached
☐ Religious Exemption Attached

☐ Provisional Admission Date Granted: ___ ___ / ___ ___ / ___ ___ ___ ___

[1] REQUIRES MEDICAL EXEMPTION.

A complete list of New Jersey's immunization requirements is accessible at: http://nj.gov/health/cd/imm_requirements

IMM-8
OCT 17

J1005

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 ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐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

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 II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination: | Results 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		

☐ ***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.***

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