Universal Health Form

Section I - To be completed by parent(s)

Child's name *(last)*	*(first)*	Gender	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 the healthcare 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	