

Universal Child Health Record

Endorsed by the Virgin Islands Department of Human Services

SECTION 1 - TO BE COMPLETED BY PARENT(S) / GUARDIAN			
Child's Name (Last) _____ (First) _____	Gender () Male () Female	Date of Birth ____ / ____ / ____	
Does the child have health insurance () Yes () 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 _____	This form may be release to the V.I. Department of Human Services () Yes () 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	(v) 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 Physical Examination: _____	Results of physical examination normal? () Yes () No		
	Height: _____	Weight: _____	
Abnormalities Noted: _____			

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 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 () Special Care Plan Attached	Comments:
Behavioral Issues/Mental Health Concerns *List behavioral/mental health issues	() None () Special Care Plan Attached	Comments:
Emergency Plans *List emergency plan that might be need and the signs/symptoms to watch for:	() None () Special Care Plan Attached	Comments:

() I have examined the child listed above & 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 & 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: _____