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	(√) 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:

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