New Jersey Department of Health and Senior Services
PO Box 364, Trenton, NJ 08625-0364

CHILD HEALTH RECORD

Patient Name (Last, First, MI)

Date of Birth	Sex	NJIIS Number

Language Spoken in Home

Name and Address of Backup Health Care Provider

PERMISSION FOR EXAMINATIONS, IMMUNIZATIONS AND TESTS:
I hereby request that my child be given the examinations, immunizations, and tests recommended by the health care provider.

(Signature)

(Date) (Relationship)

County **Mercer** Municipality **Lawrenceville**

Child Health Conference (address) **2207 Lawrence Rd. Lawrenceville, NJ 08648**

Father _____ Occupation _____

Mother _____ Occupation _____

Address* _____

Telephone* _____

**Use pencil for eventual changes.*

FAMILY HEALTH (NOTE CHRONIC ILLNESS, MENTAL ILLNESS, ALLERGIES, ETC., OR CAUSE OF DEATH)

Relation	Year of Birth	State of Health
Father		
Mother		
Brother/Sisters		

Has any relation had:	No	Yes	Relation
Significant allergy	☐	☐	
Hypertension	☐	☐	
Heart disease	☐	☐	
Diabetes	☐	☐	
Tuberculosis	☐	☐	
Convulsive disorder	☐	☐	
Mental illness	☐	☐	
Cancer	☐	☐	
Unexplained Early Death Before Age 50	☐	☐	

Additional Information: _____

PERSONAL HEALTH HISTORY

BIRTH HISTORY	NO	YES
Illness of mother during pregnancy:	☐	☐
Unusual labor or delivery:	☐	☐

Type of Delivery: _____

Birth weight: _____

Apgar score: _____

Neonatal Condition: _____

Length of Hospital Stay: _____

Place of Birth: _____

Any difficulties in first days of life: ☐ ☐

OTHER HEALTH HISTORY (Note dates of significant illnesses, injuries, hospitalizations and surgeries.):

Date of last menstrual period:

Current Medications:

Any serious reaction to vaccines?

ALLERGIES::

Medication:

Food:

Bees/Environmental:

TUBERCULIN TESTS

Date	Type/Lot No.	Reaction (mm Induration)

SCREENING

Type	Hearing*			Vision			Developmental / Ages and Stages Questionnaire (ASQ)							
Date														
Type of Test														
Result														

**Note date if SCH-2 received (6 months hearing screening):*

LAB SCREENING TESTS (IF DONE)

Type	Date	Result	Date	Result	Type	Date	Cap/Venous	Result
Hct/Hgb					Lead			
Hct/Hgb					Lead			
IEM					Lead			