

MASSACHUSETTS SCHOOL HEALTH RECORD

Health Care Provider's Examination

Name _____ Male Female Date of Birth: _____

Medical History _____

Pertinent Family History _____

Current Health History _____

Y **N** Allergies: Please list: Medications _____ Food _____ Other _____

History of Anaphylaxis to _____ Epi-Pen: Yes No

Asthma: Asthma Action Plan Yes No (Please attach)

Diabetes: Type I Type II

Seizure Disorder: _____

Other (please specify) _____

Current medications (if relevant to the student's health and safety) *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

Physical Examination _____ Date of Examination: _____

Hgt: _____ (____% Wgt: _____ (____% BMI: _____ (____% BP: _____

(Check = Normal / if abnormal, please describe.)

General Lungs Extremities

Skin Heart Neurologic

HEENT Abdomen Other

Dental/Oral Genitalia

Screening: (Pass) (Fail) (Pass) (Fail) (Pass) (Fail)

Vision: Right Eye Hearing: Right ear Postural Screening:

Left Eye Left ear Scoliosis/Kyphosis/Lordosis)

Stereopsis

Laboratory Results:

The entire examination was normal:

Targeted TB Skin Testing: Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):

Date of PPD: ____; Results: ____ mm.

Referred for evaluation to: _____ Low risk (no PPD done)

This student has the following problems that may impact his/her educational experience:

Vision Hearing Speech/Language Fine/Gross Motor Deficit

Emotional/Social Behavior Other

Comments/Recommendations: _____

This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions. _____

Immunizations are complete. If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record.

Signature of Examiner Circle: MD, DO, NP, PA _____

Please print name of Examiner

Group Practice Telephone

Address City State Zip Code

Please attach additional information as needed for the health and safety of the student

Massachusetts Department of Public Health
CERTIFICATE OF IMMUNIZATION

Name _____

Date of Birth: ____/____/____ Sex: female male

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e.g., Hep B, HepB-Hib, DTaP-HepB-IPV)	1		Haemophilus Influenzae Type b (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
	4			4	
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td, Tdap)	1		Measles, Mumps, Rubella (MMR)	1	
	2			2	
	3				
	4				
	5				
	6				
Polio (e.g., IPV, DTaP-Hep B – IPV)	1		Varicella	1	
	2			2	
	3				
	4				
	5				
Pneumococcal Conjugate (PCV7)	1				
	2				
	3				
	4				

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
*Must also check Chickenpox History Box			