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)		
Stereopis	☐	☐						

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	
Diptheria, Tetanus, Pertussis (e.g., DTaP, DT, DTap-Hib, DTap-HebB-IPV, Td, Tdap)	1		**Measles, Mumps, Rubella** (MMR)	1	
	2			2	
	3				
	4				
	5				
	6				
Polio (e.g., IPV, DTaP-Heb 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			