

MASSACHUSETTS SCHOOL HEALTH RECORD

Health Care Provider's Examination

Name _____ Male Female Date of Birth: _____

Medical History

Pertinent Family History

Current Health Issues

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Allergies: Please list: Medications _____ Food _____ Other _____ History of Anaphylaxis to _____ Epi-Pen®: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Asthma: Asthma Action Plan <input type="checkbox"/> Yes <input type="checkbox"/> No (Please attach)
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II
<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder: _____
<input type="checkbox"/>	<input type="checkbox"/>	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.)

<input type="checkbox"/> General _____	<input type="checkbox"/> Lungs _____	<input type="checkbox"/> Extremities _____
<input type="checkbox"/> Skin _____	<input type="checkbox"/> Heart _____	<input type="checkbox"/> Neurologic _____
<input type="checkbox"/> HEENT _____	<input type="checkbox"/> Abdomen _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dental/Oral _____	<input type="checkbox"/> Genitalia _____	

Screening:

	(Pass) (Fail)		(Pass) (Fail)		(Pass) (Fail)
Vision: Right Eye	<input type="checkbox"/> <input type="checkbox"/>	Hearing: Right Ear	<input type="checkbox"/> <input type="checkbox"/>	Postural Screening:	<input type="checkbox"/> <input type="checkbox"/>
Left Eye	<input type="checkbox"/> <input type="checkbox"/>	Left Ear	<input type="checkbox"/> <input type="checkbox"/>	(Scoliosis/Kyphosis/Lordosis)	
Stereopsis	<input type="checkbox"/> <input type="checkbox"/>				

Laboratory Results: Lead _____ Date _____ Other _____

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:

<input type="checkbox"/> Vision	<input type="checkbox"/> Hearing	<input type="checkbox"/> Speech/Language	<input type="checkbox"/> Fine/Gross Motor Deficit
<input type="checkbox"/> Emotional/Social	<input type="checkbox"/> Behavior	<input type="checkbox"/> Other	

Comments/Recommendations: _____

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

Y N 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 Date _____

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.

MDPH 09/14/06

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., HepB, HepB-Hib, DTaP-HepB-IPV)	1	Haemophilus influenzae type b (e.g., Hib, HepB-Hib, DTaP-Hib)	1
	2		2
	3		3
	4		
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1	Measles, Mumps, Rubella (MMR)	1
	2		2
	3	Varicella (Var)	1
	4		2
	5		
	6	Hepatitis A (HepA)	1
	7		2
Polio (e.g., IPV, DTaP-HepB-IPV)	1	Pneumococcal Polysaccharide (PPV23)	1
	2		2
	3	Influenza Inactivated (Intramuscular) or Live (Intranasal)	1
	4		2
Pneumococcal Conjugate (PCV7)	1	Other:	3
	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.			

<u>Chickenpox History</u>
<input type="checkbox"/> Check the box if this person has a physician-certified reliable history of chickenpox. Reliable history may be based on: <ul style="list-style-type: none"> • physician interpretation of parent/guardian description of chickenpox • physical diagnosis of chickenpox, or • serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name (please print) _____ **Date:** _____ / _____ / _____

Signature: _____

Facility name: _____