

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 _____
<input type="checkbox"/>	<input type="checkbox"/>	History of Anaphylaxis to _____ Epi-Pen Yes No
<input type="checkbox"/>	<input type="checkbox"/>	Asthma: Asthma Action Plan Yes No (Please attach)
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I 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)
Vision: Right Eye
Left Eye
Stereopsis

(Pass) (Fail)
Hearing: Right Ear
Left Ear

(Pass) (Fail)
Postural Screening:
(Scoliosis/Kyphosis/Lordosis)

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

This student has the following problems that may impact his/her education 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 11/30/04

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., Hip, 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			Hepatitis A (HepA)	1	
	6				2	
	7					
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			3		
	2		Other:			
	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.			

Chickenpox History
<input type="checkbox"/> Check the box if this person has a physician-certified reliable history of chickenpox. Reliable history may be based on: 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: _____