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

☐ ☐ 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_____ ☐ Lunges_____ ☐ Extremities_____
☐ Skin_____ ☐ Heart _____ ☐ Neurologic _____
☐ HEENT _____ ☐ Abdomen _____ ☐ Other _____
☐ Dental/Oral _____ ☐ Genitalia _____

Screening:

	(Pass)	(Fail)
Vision: Right Eye	☐	☐
Left Eye	☐	☐
Stereopsis	☐	☐
Hearing: Right Ear	☐	☐
Left Ear	☐	☐
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:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit
☐ Emotional/Social ☐ Behavior ☐ 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	
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1			4	
	2		**Measles, Mumps, Rubella** (MMR)	1	
	3			2	
	4		**Varicella** (Var)	1	
	5			2	
	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			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

☐ 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: _____