# 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 | ☐ | ☐ |

| | (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:

☐ 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*

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:** _____