

# MASSACHUSETTS SCHOOL HEALTH RECORD

## Health Care Provider's Examination

Name \_\_\_\_\_  Male  Female Date of Birth: \_\_\_\_\_

Medical History \_\_\_\_\_

### Pertinent Family History

### Current Health Issues

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies: Please list: Medications _____ Food _____ Other _____                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | 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

Hgt: \_\_\_\_\_ (\_\_\_\_%) Wgt: \_\_\_\_\_ (\_\_\_\_%) BMI: \_\_\_\_\_ (\_\_\_\_%) BP: \_\_\_\_\_  
(Check = Normal / If abnormal, please describe.)

Date of Examination: \_\_\_\_\_

- |  |  |  |
|--|--|--|
| <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:

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

**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 12/14/04

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	
<b>Hepatitis B</b> (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		<b>Haemophilus influenzae type b</b> (e.g., Hib, HepB-Hib, DTaP-Hib)	1		
	2			2		
	3			3		
		4				
<b>Diphtheria, Tetanus, Pertussis</b> (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1		<b>Measles, Mumps, Rubella</b> (MMR)	1		
	2			2		
	3		<b>Varicella</b> (Var)	1		
	4			2		
	5					
		6		<b>Hepatitis A</b> (HepA)	1	
		7			2	
<b>Polio</b> (e.g., IPV, DTaP-HepB-IPV)	1		<b>Pneumococcal Polysaccharide</b> (PPV23)	1		
	2			2		
	3		<b>Influenza</b> Inactivated (Intramuscular) or Live (Intranasal)	1		
	4			2		
<b>Pneumococcal Conjugate</b> (PCV7)	1			3		
	2		<b>Other:</b>			
	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:	
<ul style="list-style-type: none"> <li>• physician interpretation of parent/guardian description of chickenpox</li> <li>• physical diagnosis of chickenpox, or</li> <li>• serologic proof of immunity</li> </ul>	

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: \_\_\_\_\_