

# 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.)

<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 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 \_\_\_\_\_

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		<b>Other:</b>	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.

Chickenpox History
<input type="checkbox"/> Check the box if this person has a physician-certified reliable history of chickenpox. <b>Date of chickenpox:</b> /    /    /
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: \_\_\_\_\_