

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

**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 10/20/05

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><br>(e.g., HepB, HepB-Hib, DTaP-HepB-IPV)                            | 1 |                   | <b>Haemophilus influenzae type b</b><br>(e.g., Hib, HepB-Hib, DTaP-Hib)    | 1 |                   |
|  | 2 |                   |  | 2 |                   |
|  | 3 |                   |  | 3 |                   |
|  |   | 4                 |  |   |                   |
| <b>Diphtheria, Tetanus, Pertussis</b><br>(e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td) | 1 |                   | <b>Measles, Mumps, Rubella</b><br>(MMR)                                    | 1 |                   |
|  | 2 |                   |  | 2 |                   |
|  | 3 |                   | <b>Varicella</b><br>(Var)  | 1 |                   |
|  | 4 |                   |  | 2 |                   |
|  | 5 |                   |  | 1 |                   |
|  |   |                   |  | 2 |                   |
|  | 6 |                   | <b>Hepatitis A</b><br>(HepA)   | 1 |                   |
| 7  |   | 2                 |  |   |                   |
| <b>Polio</b><br>(e.g., IPV, DTaP-HepB-IPV)   | 1 |                   | <b>Pneumococcal Polysaccharide</b><br>(PPV23)                              | 1 |                   |
|  | 2 |                   |  | 2 |                   |
|  | 3 |                   | <b>Influenza</b><br>Inactivated (Intramuscular)<br>or<br>Live (Intranasal) | 1 |                   |
|  | 4 |                   |  | 2 |                   |
| <b>Pneumococcal Conjugate</b><br>(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**

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: \_\_\_\_\_