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)		(Pass)	(Fail)		(Pass)	(Fail)
Vision: Right Eye	☐	☐	Hearing: Right Ear	☐	☐	Postural Screening:	☐	☐
Left Eye	☐	☐	Left Ear	☐	☐	(Scoliosis/Kyphosis/Lordosis)		
Stereopsis	☐	☐						

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: