

# 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 \_\_\_\_\_

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><br>(e.g., HepB, HepB-Hib,<br>DTaP-HepB-IPV)                               | 1 |                   | <b>Haemophilus influenzae type b</b><br>(e.g., Hib, HepB-Hib,<br>DTaP-Hib) | 1 |                   |
|  | 2 |                   |  | 2 |                   |
|  | 3 |                   |  | 3 |                   |
|  |   | 4                 |  |   |                   |
| <b>Diphtheria, Tetanus, Pertussis</b><br>(e.g., DTaP, DT,<br>DTaP-Hib,<br>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 |                   | <b>Hepatitis A</b><br>(HepA)   | 1 |                   |
|  | 6 |                   |  | 2 |                   |
|  | 7 |                   |  |   |                   |
| <b>Polio</b><br>(e.g., IPV,<br>DTaP-HepB-IPV)  | 1 |                   | <b>Pneumococcal Polysaccharide</b><br>(PPV23)                              | 1 |                   |
|  | 2 |                   |  | 2 |                   |
|  | 3 |                   | <b>Influenza</b><br>Inactivated<br>(Intramuscular) 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  |
|---|
| <input type="checkbox"/> 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: \_\_\_\_\_