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 ______________ ☐ Lungs ______________ ☐ Extremities ______________
☐ Skin ______________ ☐ Heart ______________ ☐ Neurologic ______________
☐ HEENT ______________ ☐ Abdomen ______________ ☐ Other ______________
☐ Dental/Oral ______________ ☐ Genitalia ______________

Screening:

	(Pass)	(Fail)
Vision: Right Eye	☐	☐
Left Eye	☐	☐
Stereopsis	☐	☐
Hearing: Right Ear	☐	☐
Left Ear	☐	☐
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:
☐ 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 05/17/05*

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
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		***Haemophilus influenzae* type b** (e.g., Hib, 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	
☐ (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: