

# 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                        |   |                        |  |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies: Please list: Medications _____   | Food _____             | Other _____  |  |
|                          |                          | History of Anaphylaxis to _____   |                        | Epi-Pen®: <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma: Asthma Action Plan <input type="checkbox"/> Yes <input type="checkbox"/> No | <i>(Please attach)</i> |  |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II          |                        |  |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizure disorder: _____   |                        |  |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Other <i>(Please specify)</i> _____   |                        |  |  |

**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"/> | <i>(Scoliosis/Kyphosis/Lordosis)</i> |   |
| 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 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 |
|--|---|-------------------|--|---|-------------------|
| Hepatitis B<br>(e.g., HepB, HepB-Hib,<br>DTaP-HepB-IPV)                                  | 1 |                   | Haemophilus<br>influenzae type b<br>(e.g., Hib, HepB-Hib,<br>DTaP-Hib) | 1 |                   |
|  | 2 |                   |  | 2 |                   |
|  | 3 |                   |  | 3 |                   |
|  |   | 4                 |  |   |                   |
| Diphtheria,<br>Tetanus, Pertussis<br>(e.g., DTaP, DT,<br>DTaP-Hib,<br>DTaP-HepB-IPV, Td) | 1 |                   | Measles, Mumps,<br>Rubella<br>(MMR)                                    | 1 |                   |
|  | 2 |                   |  | 2 |                   |
|  | 3 |                   | Varicella<br>(Var)   | 1 |                   |
|  | 4 |                   |  | 2 |                   |
|  | 5 |                   |  |   |                   |
|  | 6 |                   | Hepatitis A<br>(HepA)  | 1 |                   |
|  | 7 |                   |  | 2 |                   |
| Polio<br>(e.g., IPV,<br>DTaP-HepB-IPV)   | 1 |                   | Pneumococcal<br>Polysaccharide<br>(PPV23)                              | 1 |                   |
|  | 2 |                   |  | 2 |                   |
|  | 3 |                   | Influenza<br>Inactivated<br>(Intramuscular) or<br>Live (Intranasal)    | 1 |                   |
|  | 4 |                   |  | 2 |                   |
| Pneumococcal<br>Conjugate<br>(PCV7)  | 1 |                   | Other:   | 3 |                   |
|  | 2 |                   |  |   |                   |
|  | 3 |                   |  |   |                   |
|  | 4 |                   |  |   |                   |

| Serologic Proof<br>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:  |  |
| <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: \_\_\_\_\_