

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:

Vision: Right Eye (Pass) (Fail) Left Eye Stereopsis
Hearing: Right Ear (Pass) (Fail) Left Ear
Postural Screening: (Pass) (Fail)
(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 04/06/05

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	
		4			
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1		Measles, Mumps, Rubella (MMR)	1	
	2			2	
	3		Varicella (Var)	1	
	4			2	
	5		Hepatitis A (HepA)	1	
	6			2	
	7				
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		Other:	3	
	2				
	3				
	4				

Serologic Proof of Immunity		Check One	
	Date of Test	Positive	Negative
<input type="checkbox"/> (if done) Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History
<p>Check the box if this person has a physician-certified reliable history of chickenpox.</p> <p>Reliable history may be based on:</p> <ul style="list-style-type: none"> • 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: _____