

# 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 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 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 \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

Please attach additional information as needed for the health and safety of the student.

MDPH 11/29/04