

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 (Please attach) | | | |
| <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 (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"/> HBENT _____ | <input type="checkbox"/> Abdomen _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dental/Oral _____ | <input type="checkbox"/> Genitalia _____ | |

Screening:

- | | | |
|---|--|---|
| Vision: Right Eye <input type="checkbox"/> (Pass) <input type="checkbox"/> (Fail) | Hearing: Right Ear <input type="checkbox"/> (Pass) <input type="checkbox"/> (Fail) | Postural Screening: <input type="checkbox"/> (Pass) <input type="checkbox"/> (Fail) |
| Left Eye <input type="checkbox"/> <input type="checkbox"/> | Left Ear <input type="checkbox"/> <input type="checkbox"/> | (Scoliosis/Kyphosis/Lordosis) |
| 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