

MASSACHUSETTS SCHOOL HEALTH RECORD

Health Care Provider's Examination

Name _____ Male Female Date of Birth: _____

Medical History

Pertinent Family History

Current Health Issues

<input type="checkbox"/> Y	<input type="checkbox"/> N	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"/> 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"/>	(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 12/06/04

