

# 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"/> 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):

TB Test Type:  TST  IGRA Date: \_\_\_\_\_ Result:  Positive  Negative  Indeterminate/Borderline

Referred for evaluation to: \_\_\_\_\_ Date: \_\_\_\_\_  Low risk (no TB test 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 09/18/13