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)
Vision: Right Eye	☐	☐
Left Eye	☐	☐
Stereopsis	☐	☐
Hearing: Right Ear	☐	☐
Left Ear	☐	☐
Postural Screening: (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 12/14/04*