

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.)

<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)
Vision: Right Eye ☐ ☐
Left Eye ☐ ☐
Stereopsis ☐ ☐

(Pass) (Fail)
Hearing: Right Ear ☐ ☐
Left Ear ☐ ☐

(Pass) (Fail)
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):

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 12/12/17