

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)	(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):
Dat of PPD: _____; Results: _____ mm.

Referred for evaluation to: _____ Low risk (no PPD done)

This student has the following problems that may impact his/her education experience:

Vision Hearing Speech/Language Fine/Gross motor Deficit
 Emotional/Social Behavior Other

Comments/Recommendations:

Yes No This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions: _____

Yes No 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 05/27/05

