# 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):
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:
☐ 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 08/15/13*