FORM B

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	☐	☐	Hearing: Right Ear	☐	☐	Postural Screening:	☐	☐
Left Eye	☐	☐	Left Ear	☐	☐	(Scoliosis/Kyphosis/Lordosis)		
Stereopsis	☐	☐						

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*