

# MASSACHUSETTS SCHOOL HEALTH RECORD

## Health Care Provider's Examination

Name \_\_\_\_\_  Male  Female Date of Birth: \_\_\_\_\_

Medical History \_\_\_\_\_

**Pertinent Family History**

**Current Health Issues**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <b>Y</b>                 | <b>N</b>                 |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies: Please list: Medications _____ Food _____ Other _____<br>History of Anaphylaxis to _____ Epi -Pen®: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma: Asthma Action Plan <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Please attach)</i>  |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II  |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizure disorder: _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Other <i>(Please specify)</i> _____   |

**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)                                     |                    | (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):  
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