# 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 04/05/17*