

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 ☐ ☐

(Pass) (Fail)
Hearing: Right Ear ☐ ☐
Left Ear ☐ ☐

(Pass) (Fail)
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):

Date of PPD: ____; Results: ____ mm.

Referred for evaluation to: _____ ☐ Low risk (no PPD 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 12/14/04