



Presentation of Mary Academy 2019-2020 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:

- Vision: Right Eye (Pass) (Fail) Left Eye Stereopsis Hearing: Right Ear (Pass) (Fail) Left Ear Postural Screening: (Pass) (Fail) (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

MUST BE RETURNED NO LATER THAN AUGUST 8, 2019



Presentation of Mary Academy 2019-2020

Massachusetts Department of Public Health CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: / /

Sex: female male

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type	
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		<i>Haemophilus influenzae</i> type b (e.g., Hib, HepB-Hib, DTaP-Hib)	1		
	2			2		
	3			3		
		4				
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1		Measles, Mumps, Rubella (MMR)	1		
	2			2		
	3		Varicella (Var)	1		
	4			2		
	5					
		6		Hepatitis A (HepA)	1	
		7			2	
Polio (e.g., IPV, DTaP-HepB-IPV)	1		Pneumococcal Polysaccharide (PPV23)	1		
	2			2		
	3		Influenza Inactivated (Intramuscular) or Live (Intranasal)	1		
	4			2		
Pneumococcal Conjugate (PCV7)	1		Other:	3		
	2					
	3					
	4					

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		

* Must also check Chickenpox History box.

Chickenpox History
<input type="checkbox"/> Check the box if this person has a physician-certified reliable history of chickenpox. Reliable history may be based on: <ul style="list-style-type: none"> • physician interpretation of parent/guardian description of chickenpox • physical diagnosis of chickenpox, or • serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name (please print) _____

Date: / /

Signature: _____

Facility name: _____

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