

LEARNING PREP SCHOOL HEALTH RECORD

Physician/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):

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 09/27/17

CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: / /

Sex: M F

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, HepA-HepB)	1			Measles, Mumps, Rubella (e.g., MMR, MMRV)	1		
	2				2		
	3			Varicella (Var, MMRV)	1		
	4				2		
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1			Meningococcal Quadrivalent MenACWY-Conjugate (MCV4) or Polysaccharide (MPSV4)	1		
	2				2		
	3			Meningococcal Serogroup B (Men B) MenB-FHbp MenB-4C	1		
	4				2		
	5				3		
	6			Seasonal Influenza Inactivated IIV4, IIV4-ID, IIV3, IIV3-ID, IIV3-HD, RIV3-IM, cclIV3-IM	1		
	7				2		
	8				3		
Haemophilus influenzae type b (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib, Hib-MenCY)	1			Live Attenuated LAIV, LAIV4 (quadrivalent)	4		
	2				5		
	3				6		
	4				7		
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1			2009 H1N1 Influenza Inactivated or Live	1		
	2				2		
	3			Pneumococcal Polysaccharide (PPSV23)	1		
	4				2		
	5				Hepatitis A (HepA, HepA-HepB)	1	
			2				
Pneumococcal Conjugate (PCV13, PCV7)	1			Human Papillomavirus (9vHPV, 4vHPV, 2vHPV)	1		
	2				2		
	3				3		
	4						
Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1			Zoster (shingles)	1		
	2			Other:	1		
	3				2		

Please see next page ➡

CERTIFICATE OF IMMUNIZATION (continued)

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: _____