

if significant medical problems

MASSACHUSETTS SCHOOL HEALTH RECORD

HEALTH CARE PROVIDERS EXAMINATION

Name: _____ M F Birth Date ___/___/___

Mother: _____ Father: _____ School: _____

Address: _____ Telephone: Home _____ Work _____

Previous Schooling: () Head Start _____ () Pre-school _____ () Transfer _____ () none

IMMUNIZATIONS

	(a)		Month	Year	(b)	Month	Year		Month	Year		Month	Year
1. DTP	DT	DTaP			1. OPV/IPV			1. HepB			1. HibT		
2. DTP	DT	DTaP			2. OPV/IPV			2. HepB			2. HibT		
3. DTP	DT	DTaP			3. OPV/IPV			3. HepB			3. HibT		
4. DTP	DT	DTaP			4. OPV/IPV			Other			4. HibT		
5. DTP	DT	DTaP			1. MMR			Other			Varicella		
Td (c)					2. MMR			Other			Lead (d)		

- (a) If a DT or DtaP is given, please circle. Mass DPH requires a letter explaining the contraindication to DTP.
- (b) If IPV is given, please circle IPV. Use IPV if the child or a contact is immunocompromised.
- (c) Mass DPH recommends a Td at age 11-12, if 5 years have elapsed since the previous DTP.
- (d) Mass General Law c 122, 12B requires evidence of previous lead screening prior to entering kindergarten.

TUBERCULOSIS SCREENING RECOMMENDATIONS

	Yes	No
1. Exposure to TB or High Risk Person – Homeless, immunocompromised, incarcerated, drug user		
2. Child/contact lived in endemic area – Africa, Latin America, Caribbean (not Puerto Rico) Asia, Mideast, E. Europe		
3. If either of the above are yes an Intermediate PPD is needed - to be read in 48 hrs. - 72 hrs.		
4. Applied ___/___/___ Read ___/___/___ Results: Neg. <input type="checkbox"/> Pos. <input type="checkbox"/> : ___ mm Referred <input type="checkbox"/> Signature: _____		

PAST MEDICAL PROBLEMS

	Yes	No		Yes	No		Yes	No		Yes	No
1. Vision			4. Prenatal/Birth			7. Frequent Ear Infection P.E. Tubes			10. Allergies		
2. Speech			5. Developmental Delay			8. Seizures			11. Significant Family History		
3. Hearing			6. Inattention/Impulsivity Hyperactivity			9. Asthma			12. Elevated Lead		

1. If any of the above are yes, please elaborate below and refer to the box number; e.g., 1. wears glasses:

2. Significant past illnesses/Hospitalizations/Operations: Varicella Yes No

3. Current Medication: Circle those to be taken in school. A separate consent sheet is needed for medication to be given in school.

4. Specialists names and addresses:

5. Any significant findings or concerns requiring an adjustment in school program? Yes No
