

Name: \_\_\_\_\_  Male  Female Date of Birth: \_\_\_\_\_

Medical History: \_\_\_\_\_

Pertinent Family History: \_\_\_\_\_

**Current Health Issues**

\_\_\_\_ Yes \_\_\_\_ No Allergies: Please list: Medications \_\_\_\_\_ Food \_\_\_\_\_ Other \_\_\_\_\_  
History of Anaphylaxis to \_\_\_\_\_ Has Epi-Pen \_\_\_\_ Yes \_\_\_\_ No  
\_\_\_\_ Yes \_\_\_\_ No Asthma: Asthma Action Plan \_\_\_\_ Yes \_\_\_\_ No (Please attach)  
\_\_\_\_ Yes \_\_\_\_ No Diabetes: \_\_\_\_ Type I \_\_\_\_ Type II  
\_\_\_\_ Yes \_\_\_\_ No Seizure disorder \_\_\_\_\_  
\_\_\_\_ Yes \_\_\_\_ No Other (Please specify) \_\_\_\_\_

Current Medications: \_\_\_\_\_

**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 Posture Screening \_\_\_\_ Pass \_\_\_\_ Fail  
Left Eye \_\_\_\_ Pass \_\_\_\_ Fail (Scoliosis/Kyphosis/Lordosis)  
Stereopsis \_\_\_\_ Pass \_\_\_\_ Fail

Laboratory Results: Lead: \_\_\_\_\_ Date: \_\_\_\_\_ Other: \_\_\_\_\_

The entire examination was normal:

Targeted TB Skin Testing:  Med – High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):

Date of PPD: \_\_\_\_\_; Results \_\_\_\_\_ mm.

Referred to 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: \_\_\_\_\_

\_\_\_\_ Yes \_\_\_\_ No **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:** \_\_\_\_\_

\_\_\_\_ Yes \_\_\_\_ No **Immunizations are complete. If no, give reasons: Please attach the Massachusetts Immunization Information System Certificate or other complete immunization record.**

Signature of examiner

Date

Please print name of examiner

Group Practice

Address

City

State

Zip

Phone

*Please attach additional information as needed for the health and safety of the student.*



### CERTIFICATE OF IMMUNIZATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: Male  Female

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

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
<b>Hepatitis B</b> (e.g., HepB, HepB-Hib, DTaP- HepB- IPV, HepA-HepB)	1		<b>Rotavirus</b>	1	
	2			2	
	3			3	
	4		<b>Measles, Mumps, Rubella</b> (MMR,MMRV)	1	
1		2			
<b>Diphtheria, Tetanus, Pertussis</b> (e.g., DTP, DTaP, DT, DTaP- Hib, DTaP-HepB-IPV, Td, Tdap)	2		<b>Varicella</b> (Var, MMRV)	1	
	3			2	
	4		<b>Meningococcal</b> Conjugate (MCV4) or Polysaccharide(MPSV4)	1	
	5			2	
	6		<b>Influenza</b> Inactivated (Intramuscular) or Live (Intranasal)	1	
	7			2	
	1			3	
<b>Haemophilus influenzae type b</b> (e.g., Hib, HepB-Hib, DTaP-Hib)	2		4		
	3		5		
	4		6		
	1		<b>Pneumococcal Polysaccharide</b> (PPV23)	1	
2		2			
<b>Polio</b> (e.g., IPV, DTaP-HepB-IPV)	3		<b>Hepatitis A</b> (HepA, HepA-HepB)	1	
	4			2	
<b>Pneumococcal Conjugate</b> (PCV7)	1		<b>Human Papillomavirus</b> (HPV)	1	
	2			2	
	3			3	
	4		<b>Other:</b>		

Serologic Proof of Immunity		Check One		Chickenpox History
Test (if done)	Date of Test	Positive	Negative	
Measles				<input type="checkbox"/> Check this box if this person has a physician-certified reliable history of chickenpox. Reliable history may be based on: - physical interpretation of parent/guardian description of chickenpox - physical diagnosis of chickenpox, or - serologic proof of immunity
Mumps				
Rubella				
Varicella*				
Hepatitis B				
*Must also check Chickenpox History box				

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: \_\_\_\_\_

Revised 1/26/09 from Massachusetts Department of Public Health Certificate of Immunization Form