

CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: / /

Gender: _____

Please indicate vaccine type (e.g., DTaP-Hib, etc.), not brand name.

Vaccine	Date	Vaccine Type	Vaccine	Date	Vaccine Type
Hepatitis B (e.g., HepB, Hep B-CpG, 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 (Trumenba) MenB-4C (Bexsero)	1	
	4			2	
	5			3	
	6		Seasonal Influenza Inactivated (e.g., IIV4, RIV4, cclIV4, IIV3, IIV3-HD, allIV3, RIV3, IIV4-ID) Live Attenuated (e.g., LAIV, LAIV4)	1	
	7			2	
	8			3	
Haemophilus influenzae type b (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib, Hib-MenCY)	1			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				
Pneumococcal Conjugate (PCV13, PCV7)	1		Hepatitis A (HepA, HepA-HepB)	1	
	2			2	
	3		Human Papillomavirus (9vHPV, 4vHPV, 2vHPV)	1	
	4			2	
Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1		Zoster (Shingles) (RZV [Shingrix], ZVL [Zostavax])	1	
	2			2	
	3			3	

Please see next page ➡

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 | |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies: Please list: Medications _____ Food _____ Other _____ |
| | | History of Anaphylaxis to _____ Epi -Pen®: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma: Asthma Action Plan <input type="checkbox"/> Yes <input type="checkbox"/> No (Please attach) |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizure disorder: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 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.)

- | | | |
|--|--|--|
| <input type="checkbox"/> General _____ | <input type="checkbox"/> Lungs _____ | <input type="checkbox"/> Extremities _____ |
| <input type="checkbox"/> Skin _____ | <input type="checkbox"/> Heart _____ | <input type="checkbox"/> Neurologic _____ |
| <input type="checkbox"/> HEENT _____ | <input type="checkbox"/> Abdomen _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dental/Oral _____ | <input type="checkbox"/> Genitalia _____ | |

Screening:

- | | | | | | |
|-------------------|---|--------------------|---|-------------------------------|---|
| | (Pass) (Fail) | | (Pass) (Fail) | | (Pass) (Fail) |
| Vision: Right Eye | <input type="checkbox"/> <input type="checkbox"/> | Hearing: Right Ear | <input type="checkbox"/> <input type="checkbox"/> | Postural Screening: | <input type="checkbox"/> <input type="checkbox"/> |
| Left Eye | <input type="checkbox"/> <input type="checkbox"/> | Left Ear | <input type="checkbox"/> <input type="checkbox"/> | (Scoliosis/Kyphosis/Lordosis) | |
| Stereopsis | <input type="checkbox"/> <input type="checkbox"/> | | | | |

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:

- | | | | |
|---|-----------------------------------|--|---|
| <input type="checkbox"/> Vision | <input type="checkbox"/> Hearing | <input type="checkbox"/> Speech/Language | <input type="checkbox"/> Fine/Gross Motor Deficit |
| <input type="checkbox"/> Emotional/Social | <input type="checkbox"/> Behavior | <input type="checkbox"/> 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