# 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 | (Pass) | (Fail) |
|---|---|---|
| Right Eye | ☐ | ☐ |
| Left Eye | ☐ | ☐ |
| Stereopsis | ☐ | ☐ |

| Hearing | (Pass) | (Fail) |
|---|---|---|
| Right Ear | ☐ | ☐ |
| Left Ear | ☐ | ☐ |

| | (Pass) | (Fail) |
|---|---|---|
| Postural Screening: (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):

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 12/14/04*

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 | | ***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib) | 1 | |
| | 2 | | | 2 | |
| | 3 | | | 3 | |
| **Diphtheria, Tetanus, Pertussis** (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td) | 1 | | | 4 | |
| | 2 | | **Measles, Mumps, Rubella** (MMR) | 1 | |
| | 3 | | | 2 | |
| | 4 | | **Varicella** (Var) | 1 | |
| | 5 | | | 2 | |
| | 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 | | | 3 | |
| | 2 | | **Other:** | | |
| | 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**

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- 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:**

# WRITTEN PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION OR MEDCIAL TREATMENT

## General Information

Name of student: ______________________ School: ________________ Grade: _____
Date of Birth: ____________ Sex: _______

Name of Parent/Guradian: ________________________________________________
**(Please Print)**
Address: ______________________________________________________________

Telephone (Home): ______________________ Telephone (Work): ______________
Telephone (Where parent/guardian can be reached in case of an Emergency): ______________

Other persons, if any, to be notified in an emergency if Parent/Guardian is unavailable:
Name: ______________________________ Telephone: ______________________
Relationship: ___________________________________________________________

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality). Please list all medications your child is receiving, including those given during the school day: 1. ______________ 2. ______________ 3. ______________ 4. ______________

**My son/daughter is known to have the following allergies:** ____________________________

## CONSENT

1. I give permission for the school nurse or school personnel designated by the school nurse to give the following medication ______________________________________
(Name of medicine or treatment)
prescribed by ___________________________ to ___________________________
(Licensed prescriber) (Name of student)

2. I give permission for my son/daughter to self-administer medication if the school nurse determines it is safe and appropriate. YES _______ NO _______

3. I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medication administration or treatment, e.g., adverse side effects, directions for administering, as she/he determines necessary for my child's health and safety. YES _____ NO _____
ANY RESTRICTIONS ON RELEASE ____________________________

4. I understand that by authorizing this medication or treatment to be given at school, this includes permission for the appropriate communications between the school nurse and the licensed prescriber related to the specific medication, treatment or condition. I further understand that I may retrieve this medication from school at any time during school hours and the medicine will be destroyed if it is not picked up by the last day of the school year.

**SIGNATURE of Parent/Guardian:** ______________________________
Relationship to student: ______________________________ **DATE:** __________

5/04

# Sample Medication Order Form

(to be completed by a licensed prescriber)

Name of Student________________________________________ Date of Birth _________

Address_______________________________________________ Grade _________
(street) (city/town)

Name of Licensed Prescriber______________________________ Title_______________

Business Phone______________________ Emergency Phone______________________

Medication______________________________________________________________

Route of administration_______________________________ Dosage________________

Frequency___________________Time(s) of Administration__________________________

*(Please note: Whenever possible, medication should be scheduled at times other than school hours).*

Specific directions or information for administration:______________________________

Date of Order______________ Discontinuation Date________________

Diagnosis*_________________________________________________________________

Any other medical condition(s)*_______________________________________________

Optional Information

1. Special side effects, contraindications, or possible adverse reactions to be observed:_____________________________________________________________
2. Other medication being taken by the student:___________________________________
   ______________________________________________________________________
3. The date of the next scheduled visit or when advised to return to prescriber:_____________
4. Consent for self administration (provided the school nurse determines it is safe and appropriate).
   Yes_____ No_____

________________________________
Signature of Licensed Prescriber

* if not in violation of confidentiality.

# TEWKSBURY PUBLIC SCHOOLS
## MEDICATION PROCEDURE

Dear Parents/ Guardians

We would like to inform you of the procedures that are in place to ensure the health and safety of children requiring medication during the school day. This includes both prescription and non-prescription or over the counter medications.

Consistent with Massachusetts General Law (105 CMR210.000) the Tewksbury Public School district requires that the following forms must be on file in your child's health record before medication administration or before allowing self -administration in school to take place.

- Signed/written consent by the parent or guardian allowing medication administration.
- Signed/written medication order. The written medication order form should be completed and signed by your child's licensed prescriber. Medication orders are valid for one school year only. Changes in medication including the dosage must be in writing from the physician.
- Signed medication plan by the school nurse and parent.

These forms are available from the school nurse.

Self- administration is allowed in only very special circumstances and only with physician orders and consultation and permission from the school nurse. No child is allowed to self-administer without the approval of the school nurse. Violation of this privilege may result in disciplinary action

Medication must be delivered to the school in a pharmacy or manufacturer labeled container by the parent or a responsible adult whom you designate. Please ask your pharmacy to provide you with separate bottles for both home and school. No more than a thirty-day supply of medicine should be delivered to the schools.

Whenever possible medication must be administered at home.

No medication will be administered unless this process is complete.

These policies are consistent with Massachusetts law.

Tewksbury Public Schools- Accident Illness Forms

To: Parents / Guardians

From: School Nurses

Re: School Health Policies

As the School year begins, it is an appropriate time to familiarize you with health policies that will take place in the coming year in the Tewksbury Public Schools.

1. ACCIDENT /ILLNESS forms are attached. Please fill out and return as soon as possible. Any recent health problem that is not reflected in your child's health record should be brought to my attention immediately. **The importance of these forms cannot be overemphasized. Please send a note regarding any changes that may occur during the year to the school nurse.**

2. All IMMUNIZATIONS dates will be checked and notification will be sent of immunizations that are required. If your child has had any immunizations in the past few years, please have all immunizations verified and signed by MD.

3. Vision screening are conducted during the year on grades K-5, 7 and 10.

4. **Postural Screening is conducted on all students in Grades 5 – 9**. This is mandated by the state of Massachusetts. You will be notified prior to the screening.

5. **State law in grades K, 4, 7, & 10 mandates school physicals**. Physical exam forms were sent out in the spring. In addition, most Doctor's offices have a similar form of their own. Please return all completed forms by October 1st.

6. **Medication: Please call the school nurse in your child's school for medication order and parental permission forms. NO Medication, prescription or over the counter can be administered without these forms. All medication must be in a pharmacy labeled container or original manufacturer's container. Please refer to the attached medication policy**

7. **Illness: Please call the school when your child is absent**. It is important that some of these illnesses be reported to the board of health, and to parents of other students who may be susceptible to complications of those illnesses. A Doctor's note is **required** when the student returns to school when there are any restrictions in activity or phys ed. (including the nature of the restriction and the time length of the restriction). This policy also applies to injuries, fractures and sprains.

If you have any other questions or concerns, please feel free to call or set up an appointment.

# Tewksbury Public Schools- Accident Illness Forms

**To the Parents of school pupils:**

In the case of accident, illness, or other emergency, school principals must be able to locate the parent or some other person who will care for the child. We must have on file the names and phone numbers of two other persons who may be called to take care of the child if the parents cannot be reached. Please supply the information requested below and return this report to the school promptly. Thank you for your cooperation.

Pupil's name ________________________________ Date: ________ Grade: ________

Name of Parent/Guardian ________________________________ Lives with ________________

Home Address ________________________________ phone ________________

Father's occupation ________________________________ Business phone ________________

Pager ____________ Cell ________________ Email ________________________________

Mother's occupation ________________________________ Business phone ________________

Pager ____________ Cell ________________ Email ________________________________

Name of two persons who may be called to take care of the child in the absence of the parents:

Name: ________________________ Address: ____________________ Phone ________________

Name: ________________________ Address: ____________________ Phone ________________

In case we cannot get in touch with you and your child needs emergency medical attention, do you authorize this at your own expense? Yes __ No__ If no, what do you wish to be done? ____________

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Name of Health Insurance ________________________________________________

Name of Doctor: ________________ Address ____________________ Phone ____________

May we have permission to contact the child's primary care provider? Yes __ No__

Name of preferred Hospital ________________________________________________,

Please note: The Tewksbury Fire Department will be called and the child will be transported to a local hospital for treatment at their discretion.

Name of dentist: ________________ Address ____________________ Phone ____________

Please list any illness or accidents, which your child has had, or treatments they receive, or medications they take so that we may include them on the health record: ________________________________

________________________________________________________________

Does your child have allergies? Yes __ No __ If yes, to what? ________________________

Some medical information, especially food allergies, asthma and others need to be shared with supervising adults (such as bus drivers, lunchroom staff, teachers and specialists) who may be responsible for your child's safety. Are there any restrictions to us sharing this information? Yes___ No___

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PLEASE NOTIFY THE SCHOOL OF ANY CHANGES IN THE ABOVE INFORMATION

Signature of Parent/Guardian ________________________________________________