

Dear Physician:

_____ child's name is enrolled in an early childhood program licensed by the Department of Early Education and Care. The Department of Early Education and Care's regulations require at the time of admission a written statement from a physician as evidence of each child's annual physical examination, immunizations and lead screening in accordance with Department of Public Health's recommended schedules. A prompt response is appreciated.

Evidence of a physical exam is valid for one year from the date the child was examined and must be renewed annually thereafter.

IDENTIFICATION

Name of Child _____ Date of Birth _____

Address _____ Phone _____

Name of Parents _____

Address _____

Date of Examination of Child _____

What is your opinion concerning the child's general health and appearance? _____

Has this child been screened for lead poisoning? Yes _____ No _____

If YES, date screened: _____ Results _____

Does this child have any disabilities or chronic medical problems (allergies, limited vision, etc.) which require special consideration or care by the child care provider? If so, please detail below:

Physician's Signature _____

Date _____ Comments _____

Please return to Program YMCA in Greenfield Preschool
451 Main Street
Greenfield, MA 01301
Fax #: 413-774-4312

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.)

<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)
Vision: Right Eye
Left Eye
Stereopsis

(Pass) (Fail)
Hearing: 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):

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

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		Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1	
	2			2	
	3			3	
	4				
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1		Measles, Mumps, Rubella (e.g., MMR, MMRV)	1	
	2			2	
	3		Varicella (e.g., Var, MMRV)	1	
	4			2	
	5		Meningococcal Conjugate (MCV4), Hib-MenCY or Polysaccharide (MPSV4)	1	
	6			2	
	7				
Haemophilus influenzae type b (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib, Hib-MenCY)	1		Seasonal Influenza Inactivated IIV3, IIV4, cclIV3-IM, IIV3-ID, IIV3-HD	1	
	2		RIV3-IM	2	
	3		Live Attenuated LAIV, LAIV4	3	
	4			4	
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 (e.g., HepA, HepA-HepB)	1	
Pneumococcal Conjugate (PCV7, PCV13)	1			2	
	2			3	
	3		Human Papillomavirus (HPV4, HPV2)	1	
	4			2	
			Other:		

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: _____