Middlesex School Health Record
Health Care Provider's Examination

Name:_____ Male _____ Female_____ Date of Birth_____

Date of Examination:_____

Medical and Surgical History: _____

_____

Pertinent Family History:_____

Current Health Issues:

Y	N	
□	□	**Allergies** Please list: Medications_____ Food _____ Other_____
□	□	Hx of anaphylaxis to _____ Epi-Pen? Yes_____No_____
□	□	Asthma: Asthma Action Plan? Yes (please attach)_____ No _____
□	□	Diabetes: Type I Type II
□	□	Seizure disorder: _____
□	□	Menstrual irregularities/ Disorders: _____
□	□	Other (Please specify): _____

Current Medication List: ***A separate medication order form required for each prescription medication to be used at school***

Physical Examination: Ht:_____ (_____%) Wt: _____ (_____%) BMI:_____ (_____%)

Check= Normal / If abnormal, please describe:

General:_____ Lungs:_____ Extremities:_____
Skin:_____ Heart:_____ Neurologist:_____
HEENT:_____ Abdomen:_____ Other:_____
Dental/Oral:_____ Genitalia:_____ Blood Pressure :_____ Pulse_____
Laboratory Results:Hct/Hgb; UA; sickle cell trait date & result; other (specify) _____ Date ___

The entire exam was normal: Yes No Immunizations given this visit:_____

Targeted TB Testing: _____Low Risk (no PPD done)
_____Med-High Risk (exposure to TB; born, lived in, traveled to TB endemic countries; med risk factors)
Date of PPD:_____ Results: _____mm.
Referred for evaluation to:_____

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 all athletics, without restrictions.
If no, list restrictions: _____
_____Y_____N Immunizations are complete. If no, give reason.
For new students: please attach Mass. Certificate of Immunization or other complete immunization record.

_____
Signature of Examiner *Circle*: MD, DO, NP, PA Date *Please print name of examiner*

_____
Name of Practice Telephone Number

_____
Address of Practice (include city, state, zip)

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

See reverse side for Certificate of Immunization