

MASSACHUSETTS SCHOOL HEALTH RECORD

School _____ **Female** **Year of Graduation** _____
Name _____ **Male** **DOB** ___ / ___ / ___ **Primary Language Spoken (home)** _____
Last First Middle **Place of Birth** _____
Street _____ **City/Town, State, Zip Code** _____

Contact Information

Emergency Contact Information

(1) Parent/Guardian:		(2) Parent/Guardian:		(1) Emergency Contact				(2) Emergency Contact			
Name & Mailing Address if different:		Name & Mailing Address if different:		Name & Phone Number:				Name & Phone Number:			
Phone Numbers		Phone Numbers		Primary Care Provider				Dental Care Provider			
Home		Home		Name:				Name:			
Work		Work		Phone Number:				Phone Number:			
Cell		Cell		Health Insurance:							
FAX		FAX		Allergies:							

Primary Custody (if not joint) _____

General				Growth			Vision						Hearing				Postural			
School District	Year	Grade	Age	Ht.	Wt.	BMI	Preschool Certificate Yes <input type="checkbox"/> No <input type="checkbox"/>						Left Ear		Right Ear		Pass		Refer	
							Left Eye		Right Eye		Stereopsis									
							Pass	Refer	Pass	Refer	Pass	Refer	Pass	Refer	Pass	Refer				
		Pre K																		
		K																		
		1																		
		2																		
		3																		
		4																		
		5																		
		6																		
		7																		
		8																		
		9																		
		10																		
		11																		
		12																		

Special Testing **Lead** Date ___ / ___ / ___ **Tuberculin** 1. Date of PPD ___ / ___ / ___ ; result _____ mm; 2. Date of PPD ___ / ___ / ___ ; result _____
 Low risk (no PPD done)

*School District on Waiver in accordance with MGL c71,s57 indicated by * in 'Grade' column.

- **Immunizations:** Please attach complete Massachusetts Immunization Certificate/record
- Due to software differences, this form may be used as a template for other formats. (All information on this form must be included.)