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

(1) Parent/Guardian:		**(2) Parent/Guardian:**
Name & Mailing Address if different:		Name & Mailing Address if different:
Phone Numbers		Phone Numbers
Home		Home
Work		Work
Cell		Cell
FAX		FAX

Emergency Contact Information

(1) Emergency Contact	**(2) Emergency Contact**
Name & Phone Number:	Name & Phone Number:
Primary Care Provider	**Dental Care Provider**
Name:	Name:
Phone Number:	Phone Number:
Health Insurance: **Allergies:**	

Primary Custody (if not joint) _____

General				**Growth**			**Vision**						**Hearing**				**Postural**	
							Preschool Certificate Yes ☐ No ☐											
School District	**Year**	**Grade**	**Age**	**Ht.**	**Wt.**	**BMI**	**Left Eye**		**Right Eye**		**Stereopsis**		**Left Ear**		**Right Ear**			
							Pass	**Refer**	**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.)