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	
							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																
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		6																
		7																
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		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.)

April. 05