

## MASSACHUSETTS SCHOOL HEALTH RECORD

**School Name** \_\_\_\_\_ **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		<b>Primary Care Provider</b>				<b>Dental Care Provider</b>			
Home		Home		Name:				Name:			
Work		Work		Phone Number:				Phone Number:			
Cell		Cell		<b>Health Insurance:</b>							
FAX		FAX		<b>Allergies:</b>							

**Primary Custody** (if not joint) \_\_\_\_\_

General				Growth			Vision						Hearing				Postural	
							Preschool Certificate		Yes 🍏		No 🍏		Left Ear		Right Ear			
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																
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		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.)