Dear Parent or Guardian of an Incoming New Braintree Student:

Welcome to the Braintree Public Schools! Enclosed please find the following forms to be completed by the parent/guardian of a new incoming student:

1. Student Data Form
2. Verification of Residency and Affidavit of Residency based on your living situation:
   - If the parents/guardians own a home in Braintree, they must complete the form entitled, "Affidavit of Residency (Homeowners)"
   - If the parents/guardians rent a property in Braintree and can provide a lease, the **Landlord** must complete the form entitled, "Affidavit of Residency/Landlord Living Agreement"
   - If the parents/guardians live in a property in Braintree, but do so as tenants-at-will (no lease), or for no payment to the owner of the property, the **Owner/Lessee** of the property must complete the form entitled, "Affidavit of Residency by Owner/Lessee
3. Home Language Survey
4. Transfer Student Record Request
5. Nursing Services Handout
6. Medical History Form
7. MA School Health Record to be completed by your child's ***physician***
8. Certificate of Immunization

   Please pay close attention to the following list of required immunizations:
   - 5 DTaP/DPT (4 doses for PK)
   - 4 Polio (3 doses for PK)
   - 2 MMR Vaccines (1 dose for PK)
   - 3 Hepatitis Vaccines
   - 2 Varicella Vaccine (1 dose for PK) or Documented Case of Chicken Pox by physician
   - 1 Tdap for entry to grade 7 through 11
   - Recent assessment of risk for TB - Low risk students are cleared for school entry. If the student is coming from outside of the US, consult with the school nurse. The MA Department of Public Health TB testing guidelines will be followed: http://www.mass.gov/eohhs/docs/dph/cdc/tb/tb-pediatric-risk-assessment-form.pdf
   - **Kindergarten entry only (in addition to the above)** – Lead Screening with test results and a Vision screening including stereopsis – within the past 12 months
   - **Pre-Kindergarten entry only (in addition to the above)** – 1-4 Hib (number of doses determined by vaccine product and age the series begins)

   As per State Law, your child must have all required immunizations, a physical examination, and documentation of a low risk TB assessment before he/she may enter school. Children entering kindergarten must also have Lead screening test results and a vision screening with stereopsis. Should you have any questions, please feel free to contact the school principal.

9. Massachusetts Transfer Card from the child's previous school with the Child's Mass ID number listed AND an ***original*** Birth Certificate is required. The administrative assistant will make a copy of it and return the original to you.
10. Emergency Medical Card is available from your school's administrative assistant and must be completed when the above mentioned paperwork is returned.

Student Data Form
2018-2019

For Office Use Only:
Registration Date:____________________
☐Home Language Survey ☐ESL
☐SPED ☐IEP Received
Proof of Residency:☐Requested ☐Attached

Note: It is extremely important that you notify us if a change occurs in this information any time during the year.

Student

Last Name:______________________ First Name:______________ Middle Name:____________

Address:______________________ DOB:______________ ☐Male ☐Female

Home Phone:______________ Cell Phone:__________ Email:______________

Country of Birth:______________ City of Birth:__________ 1st Home Language:__________

If Born Out of the Country, # Years in U.S.:______________ Hispanic / Latino ☐Yes ☐No (of Cuban, Mexican, Puerto Rican, South/Central American Culture)

Race: ☐Caucasian ☐Native American ☐African American ☐Asian ☐Pacific Islander

Has student ever been enrolled in Braintree Public Schools? ☐Yes ☐No If yes, list school and year(s):______________

School last attended:______________________ This school was ☐Public ☐Private

Who has legal custody of this student? ☐Both Parents ☐Mother ☐Father ☐Guardian ☐Other (Specify)______________

Contact 1 Relationship: ☐Mother ☐Father ☐Guardian

Name:______________________ Address:______________________

Primary Phone:______________________ Work Phone:______________________

Alternate Phone:______________________ Primary Email:______________________

Employer Name:______________________ Occupation:______________________

Contact lives with student? ☐Yes ☐No Contact can pick up student? ☐Yes ☐No Contact may receive school mailings? ☐Yes ☐No

Contact 2 Relationship: ☐Mother ☐Father ☐Guardian

Name:______________________ Address:______________________

Primary Phone:______________________ Work Phone:______________________

Alternate Phone:______________________ Primary Email:______________________

Employer Name:______________________ Occupation:______________________

Contact lives with student? ☐Yes ☐No Contact can pick up student? ☐Yes ☐No Contact may receive school mailings? ☐Yes ☐No

Military Family Status *(in support of the VALOR Act)*
Is your student a child of an active duty member of the uniformed services/National Guard/Reserves on active duty orders? ☐Yes ☐No
Is your student a child of a member or veteran who is medically discharged or retired within one year? ☐Yes ☐No
Is your student a child of a member who died while on active duty? ☐Yes ☐No

Siblings *(please list all siblings and their dates of birth)*

Name:______________ Date of Birth:__________ Name:______________ Date of Birth:__________

Name:______________ Date of Birth:__________ Name:______________ Date of Birth:__________

Emergency Contacts *(Please notify these people that they may be notified in case of an emergency), In case of accident or acute illness of my child, when I cannot be reached promptly, kindly contact the following local persons:*

Name:______________ Relationship:__________ Phone #s: Home:__________ Cell:__________ Work:__________

Name:______________ Relationship:__________ Phone #s: Home:__________ Cell:__________ Work:__________

For Office Use Only:

Grade:______________ Teacher:__________ LASID:__________ Date Records Requested:__________

Homeroom______________ Counselor:__________ SASID:__________ Date Records Received:__________

House:______________ Social Worker:__________ Played Varsity Sports ☐Yes ☐No

Bus:______________ ☐Forwarded to Counselor ☐Forwarded to Nurse

Updated June 2018

Verification of Residency

Note: This certification form is required as part of the registration process for all students.

Name of School:____

Name of Student(s):____ Date of Birth:__________________

____ Date of Birth:__________________

Residency/Address:____

House # Street Apartment # Zip Code

☐ Check here if homeless or living in a shelter

☐ Check here to indicate agreement that you will notify school authorities of any change of address without delay

I understand that a student MUST reside in Braintree to attend the Braintree Public Schools. As the adult with whom this student is now residing at the address shown above, I certify that I am the student's (check one):

☐Parent ☐Legal Guardian ☐Other (Please Specify)________________________________

If the person with whom the child is living in Braintree has legal custody/guardianship, then with proof of custody/guardianship, the child may continue to attend school at no cost. If the person with whom the child is living in Braintree does not have legal guardianship, we would require the parent to pay tuition to attend Braintree Public School. (Chapter 76, Section 6). Currently the tuition rate is $69.92/day or $12,585.00 annually.

Students found not to be residing at the location specified will not be allowed to attend the Braintree Public Schools. Signed Under the pains and penalties of perjury:

Parent/Guardian Signature:____________________________________ Today's Date:__________________`

Before a student is enrolled in the Braintree Public Schools, the parent/legal guardian must provide proof of residency by presenting required documents from each of the columns below and any other documents that may be requested. If you are not able to produce the required documents, you must contact the Superintendent of Schools.

Column A
(*Affidavit of Residency **and** one other)
Evidence of Residency

- Affidavit of Residency – appropriate form signed and notarized **and**:
- Record of recent mortgage payment and/or property tax bill
- Copy of lease and record of recent rental payment
- Record of recent rental payment
- Section 8 agreement

Column B (1 document)
Evidence of Occupancy

- Recent bill dated within the past 60 days showing Braintree address:
- Gas bill
- Oil bill
- Electric bill
- Telephone bill
- Cable bill
- Excise tax bill

Column C (1 document)
Evidence of Identification (Photo ID)

- Valid driver's license
- Valid MA photo id card
- Passport

* Mandatory

Enforcement of Residency Requirements

Should a question arise concerning any student's residency in the Town of Braintree while attending the Braintree Public Schools, the student's residency will be subject to further inquiry and/or investigation. Such questions concerning residency may arise on the basis of incomplete, suspicious, or contradictory proofs of address; anonymous tips; correspondence that is returned to the public schools of Braintree because of invalid or unknown address, or other grounds. The Superintendent may request additional documentation, may use the assistance of the School Department's Safety Officer/Police Officer, and/or may obtain the services of the Police Department to conduct investigations into student residence. The Officer and/or residency investigator will report his/her findings to the Superintendent of Schools, who shall make final determination of residency. Upon initial determination by the Superintendent that a student is actually residing in a city or town other than the Town of Braintree, the student's enrollment in the Braintree Public Schools shall be terminated immediately.

Updated June 2018

• 348 Pond Street • Braintree, MA 02184 • Telephone (781) 380-0130 • FAX (781) 380-0146 • www.braintreeschools.org •

Affidavit of Residency (Homeowners)

I/we, the undersigned parents(s) or legal guardian(s) of________________________________, hereby certify as follows:

1. I/we reside at____
   Home # Street Apartment# Zip Code

   Telephone: Home: ______________________________ Cell: ____________________________

2. I/we wish to enroll/continue the enrollment of the above named student in the Braintree Public Schools for the __________ school year.

   I/we understand that pursuant to Massachusetts law and Braintree Public Schools Committee policy, students who actually reside in the Town of Braintree may attend the Braintree Public Schools and students who do not actually reside in the Town of Braintree may not attend the Braintree Public Schools, unless a policy exception applies. I/we hereby acknowledge that no such policy exception applies to the above-named student.

3. I/we hereby certify that the above named student resides with me at the Braintree, Massachusetts address shown on this form.

4. I/we acknowledge that I am/we are required to notify the Principal/Assistant Principal of the above student's school, in writing, of any change in said student's address within five (5) calendar days of such change of address and to provide new proof of residency pursuant to the Braintree Public Schools Admission policy.

5. I/we understand that this affidavit will be relied upon by the Braintree Public Schools for the purpose of determining the above student's eligibility to attend the Braintree Public Schools on the basis of residency. If said student is enrolled in the Braintree Public Schools based upon the information contained in this affidavit and it is subsequently determined that the student does not actually reside in Braintree, I/we understand that the student's enrollment in the Braintree Pubic Schools may be promptly terminated and I/we may be held jointly and severally liable to the Braintree Public Schools for the student's tuition for the full academic year.

6. I/we further certify that I am/we are the parents(s) or legal guardian(s) of the above student.

Signed under the pain and penalties of perjury on this ___________________________________
(Day) (Month) (Year)

____ ____
Parent/Guardian 1 Parent/Guardian 2

Printed Address: ____

*****Notarized Document Required For All New Registrations*****

Notary Public:____

County: _____________, State: _____ personally appeared and subscribed and sworn before me, this, the _____day of __________________, 20_____.

The information contained in this legal affidavit is subject to verification by a residency investigator.

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Affidavit of Residency/Landlord Living Agreement (to be filled out by owner/landlord)

To: Braintree Public Schools

From: ____

Address: ____

Phone #: ______________________________

I hereby certify and swear under oath that I am the legal owner/renter of the property at (address):____________________

I also certify and swear that (name of parent(s)/guardians):____and

their child/children (names): ____

are my tenants and live at the above address.

I agree that if the Braintree Public Schools investigate and find these statements to be false, that I may be responsible for repayment of any tuition or educational costs due to the Braintree Public Schools for the education of the above referenced children.

I agree that if the tenants listed above move out of the dwelling listed above, that I will notify the Braintree Public Schools of this change of residence.

Signed under the pain and penalties of perjury on this ___________________________________
(Day) (Month) (Year)

______________________________ ______________________________
Signature Printed Name

*****Notarized Document Required For All New Registrations*****

Notary Public:____

County: _____________, State: _____ personally appeared and subscribed and sworn before me, this, the _____day of __________________, 20_____.

The information contained in this legal affidavit is subject to verification by a residency investigator.

For Official Use Only:
Current Lease or Landlord Living Agreement and most recent Rent Payment _______________

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Affidavit of Residency by Owner/Lessee

Instructions:
Any applicant for the Braintree Public School System who cannot produce a property deed or lease must ask the **owner or lessee of the property** where the applicant lives to complete and sign this legal affidavit. It is the **responsibility of the applicant (not the person who completes this affidavit) to attach a record of recent rent payment**, unless this affidavit affirms in #3 below that the tenancy does not require payment or rent.

My name is:____and I hereby depose and certify as follows:

1. I am the owner/lessee of the property located at________________________________ in the Town of Braintree.
2. ____, who is the parent or legal guardian of ____, leases or subleases this property as their principal residence from me, without a written lease, in a tenancy at will, from month to month.
3. Check one:
   - ☐ I have received within the last thirty (30) days, rental payment for the lease or sublease of these premises.
   - ☐ Alternatively, I hereby state that the party named above resides with me at the address above with no payment of rent.

I agree that if the Braintree Public Schools investigate and find these statements to be false, that I may be responsible for repayment of any tuition or educational costs due to the Braintree Public Schools for the education of the above referenced children. I agree that if the tenants listed above move out of the dwelling listed above, that I will notify the Braintree Public Schools of this change of residence.

Signed under the pain and penalties of perjury on this ___________________________________
(Day) (Month) (Year)

____ ____
Signature Printed Name

Printed Address: ____

*****Notarized Document Required For All New Registrations*****

Notary Public:____

County: _____________, State: _____ personally appeared and subscribed and sworn before me, this, the _____day of __________________, 20_____.

The information contained in this legal affidavit is subject to verification by a residency investigator.

For Official Use Only: *Receipt of Most Recent Rent Payment* _________________ ***(if applicable)***

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Home Language Survey

Massachusetts Department of Elementary and Secondary Education regulations require that *all* schools determine the language(s) spoken in each student's home in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students. **If a language other than English is spoken in the home, the District is required to do further assessment of your child to determine if English language support services (ESL) is required.** Please help us meet this important requirement by answering the following questions. Thank you for your assistance.

Student Information

____ ☐Female ☐Male

First Name | Middle Name | Last Name | Gender

________________ ________________ ________________

Country of Birth | Date of Birth (mm/dd/yyyy) | Date first enrolled in any U.S. school (mm/dd/yyyy)

School Information

________________ ________________________________ ____________

Start Date in New School (mm/dd/yyyy) | Name of Former School and Town | Current Grade

Questions for Parents/Guardians

- What is the primary language used in the home, regardless of the language spoken by the student?______________________
- Which language(s) are spoken with your child? (include relatives: grandparents, uncles, aunts, etc. and caregivers)
  - ____________________________________ ☐seldom ☐sometimes ☐often ☐always
  - ____________________________________ ☐seldom ☐sometimes ☐often ☐always
- What language did your child first understand and speak? _______________
- Which language do you use most with your child? _____________________
- How many years has the student been in U.S. Schools? (not including pre-kindergarten) ____________
- Which languages does your child use? (check one)
  - ____________________________________ ☐seldom ☐sometimes ☐often ☐always
  - ____________________________________ ☐seldom ☐sometimes ☐often ☐always
- Will you require written information from school in your native language? ☐Yes ☐No
  - If yes, what language? _________________________________
- Will you require an interpreter/translator at Parent-Teacher meetings? ☐Yes ☐No
  - If yes, what language? _________________________________

____ ______________________

Parent/Guardian Signature | Today's Date: (mm/dd/yyyy)

Transfer Student Record Request

Former School Name: ____

Former School Address: ____

Dear Sir/Madam:

________________________is enrolling in grade_____ at_____________________School,

address____________________________________, phone ______________________

fax _____________________.

We request that you send by mail or fax the following records/information:

- ☐ State identification number
- ☐ MA transfer card
- ☐ Academic & test records (including MCAS & PARCC records and transcripts for high school students)
- ☐ Health & immunization records
- ☐ Special Education records (including IEP, evaluations and behavior management plan)
- ☐ Section 504 plan or any record of a plan within the last calendar year.
- ☐ Attendance records
- ☐ Discipline records
- ☐ Other pertinent information or background information that may aid us in working with this student (including guidance data)

to their new school which is located at: ______________________________, Braintree, MA 02184.

Thank you for your prompt attention in this matter.

Sincerely,

______________________________	______________________________
Print Parent/Guardian Name	*Parent/Guardian Signature*
______________________________	______________________________
Former Address	*New Braintree Address*

Education Reform Act of 1993: Permission of the parent or adult student is no longer required when records are requested by authorized school personnel. See Federal Law 99.31 – Family Rights Privacy Act Final Rule on Educational Records Federal Register June 17, 1976, also Section 37, Section 37L of Chapter 71 of General Laws, as appearing in the 1997 Official Edition, is hereby amended by adding the following… "A student transferring into a local system must provide the new school system with a complete school record of entering student. Said record shall include, but not be limited to, any incidents involving suspension or violation of criminal acts or any incident reports in which such student was charged with any suspended act." *Updated June 2018*

Nursing Services
Preschool – Grade 12

A Healthy Student
Is A More Effective Learner

School Nurses
Make It Happen

School Health Services

Braintree Public School nurses are essential members of the educational team responsible for promoting, protecting and improving the health status of all students. The unique role of the school nurse is to provide professional health care by coordinating services between home, school and community. The school nurse assists in maximizing each child's potential to learn and grow by providing the best possible health care. Health care provided includes: identifying health problems; preventative health measures; maintaining and promoting health and learning; promoting healthy lifestyles in students, families and staff; acute and emergency care; health counseling; mandated screenings; immunization monitoring and adherence to state regulations; medication administration and evaluation; comprehensive and appropriate health education to students, parents and staff; skilled nursing care and management of children with special health care needs; individual health care planning; school nurse and parent conferences; health input to special education meetings; review and interpretation of medical and health records. Braintree Public School nurses have the professional education and expertise to function successfully in the complex system of education and health.

State Mandated Physical Exams

Physical examinations by the student's own physician are required upon entering Preschool, Kindergarten, and grades 4, 7 and 10.

MIAA Sports Physicals

MIAA rules clearly state that any student who wishes to try out, practice or play a sport is required to have a current (within twelve months) physical exam on file in the nurses office **BEFORE** being allowed to try out or practice. If the physical exam expires during a sports season, the student must have a new physical on file prior to the expiration date of the previous physical or will be unable to play. Please plan ahead.

Mandated Screenings

Hearing - Preschool, K-3, grade 7 & 10
Vision - Preschool, K-5, grade 7 & 10
Height, Weight, BMI - Grades 1, 4, 7, 10
Postural (scoliosis) - Grades 5-9
SBIRT – Grade 7 and 9

All screenings are preformed in accordance with the Commonwealth of Massachusetts regulations. Students may also be screened at any time during the year at a teacher or parent's request. If screening results indicate the need for follow-up care by a physician, parents/guardian will be notified in writing.

Immunizations

All students must present evidence of immunizations in compliance with the requirements of Massachusetts General Laws, Chapter 76, Section 15, which specifically prohibits admitting a student to school without a physician verifying that, unless religious or medical exemptions apply. Medical and Religious exemptions must be submitted to the Health Office annually. Children need to be immunized against Diphtheria/Pertussis/Tetanus, Measles/Mumps/ Rubella, Polio, Hepatitis B, Varicella and Haemophilus Influenzae type B (HIB-Preschool requirement only). Children who are not fully immunized against these preventable illnesses are not allowed to attend school.

Medication Policy

Braintree Public Schools policy requires that a parent/guardian and a licensed provider (either a physician or nurse practitioner) sign consent for medications (including inhalers) to be given by the nurse during school hours.

- **All medications must be brought to school by a parent/guardian or designated adult in the original labeled container from the pharmacy.**
- An individual medication plan will be developed and must be signed by both parent/guardian and nurse. Only a 30-day supply of medication may be kept at school. *No child is permitted to bring medications to school or carry medication in school with the exception of an inhaler, Epinephrine auto injector or if wearing an insulin delivery system (pump).* Students may carry their own inhaler &/or Epinephrine auto injector and/or insulin delivery system only after contacting the school nurse and providing a physician medication order form and parental permission form. Call your school nurse for more information.
- For short-term medications (less than 10 days), such as antibiotics, parental consent is required. However, the prescription on the bottle is sufficient for physician consent.

When To Keep Your Child Home From School

- If your child has a fever of 100.4ºF or above.
- If your child has a contagious illness such as chicken pox, strep throat, or flu.
- If your child has a skin rash or condition not yet diagnosed by a physician.
- If your child is vomiting or has diarrhea.
- If your child's eye is pink or red, itchy and/or drainage from the eye is present.
- If your child has an active case of head lice.

Communicable Disease Control

In order to insure adherence to Massachusetts immunization requirements, monitoring of infections and other diseases are important functions of the school nurse. The nurse works with parents, administrators, school staff, primary care providers, local and regional Boards of Health, school physician and others to maintain a healthy school environment. Upon recommendation to administration, students may be excluded from school if immunizations are not up to date or if a student has a communicable disease such as chicken pox, pertussis, scabies or conjunctivitis.

FYI

- If your child becomes ill while at school, every attempt will be made to contact a parent to make arrangements to take the child home.
- Injuries at school, if severe, will be handled as an emergency situation and local EMS will be called to take your child to the most appropriate receiving hospital. Parents will be notified immediately if an ambulance is called.
- If your child needs to be excused from physical education class, notification in writing is mandatory from both parent and physician. Written documentation is required for return to physical education class as well.
- ***Parents are expected to keep emergency contact numbers up to date***. If the information for yourself or other emergency contacts changes, please notify the school nurse immediately.

Student Health Records

An individual health record is kept on file for each student throughout his or her school career. This record includes a health history, immunizations, and physical exams, screening results, health office visits and medication administration logs. Parents are asked to communicate directly with the school nurse about student health concerns, medical reports and/or issues. Student health records are strictly confidential and information will only be shared with other staff members according to FERPA guidelines.

Individual Health Care Plans (IHCP)

When a student has a specialized medical need or diagnosis which must be assessed, managed, and monitored during school, such as asthma, a life threatening allergy, or diabetes, the nurse in collaboration with the parent will make an IHCP. This plan is based on the student's individual need, medical history, and physician's order. The IHCP is then reviewed, signed by the nurse, parent and physician (when necessary) and then shared with appropriate staff to ensure optimal integration of the student's health needs into the school setting. In some instances, an emergency medical plan is also developed to expedite identification and treatment of a student with a life-threatening diagnosis.

Nurse as Educator

The school nurse teaches individual students, parents and staff about health and wellness issues and strives to promote an understanding of student health needs. At the elementary level, school nurses do formal classroom teaching on hand washing, dental health, hygiene and growth and development to name a few. At the secondary level, the school nurse works in collaboration with the health teacher to provide information and assist in presentations based on the needs of the student population

Massachusetts offers free or low cost health and dental insurance to all children and teens through age 18.
Call your school nurse or Health Care for All at 1-800-272-4232 for more information or www.hcfama.org.

School	Name	Phone	Fax
Director School Nursing Services	RN	781-848-4000 ext. 7840 (TTY 781-843-6973)	781-843-7058
Integrated Preschool Program	Margaret Ciulla, R.N.	781-848-4000 ext. 7032	781-843-7058
Monatiquot Kindergarten Center	Julie Moran, R.N.	781- 794-8423 ext. 8030	781-380-0220
Mary Flaherty Elementary School	Judy Sellon, R.N.	781-380-0153 ext. 3530	781-380-3349
Highlands Elementary School	Karen Hubbard, R.N.	781-380-0193 ext. 4530	781-380-3528
Hollis Elementary School	Jane Bagley, R.N.	781-380-0149 ext. 5030	781-380-3821
Liberty Elementary School	Joanne Kelly, R.N.	781-380-0210 ext. 5530	781-848-3790
Morrison Elementary School	Cheryl Campbell, R.N.	781-380-0230 ext. 6030	781-849-0192
Donald Ross Elementary School	Heidi Olson, R.N.	781-356-5308 ext. 6530	781-843-7606
East Middle School	Mary Ann O'Rourke, R.N. Ellen Wright, R.N.	781-380-0170 ext. 3031 781-380-0170 ext. 3030	781-848-4522
South Middle School	RN R.N	781-380-0160 ext. 4031 781-380-0160 ext. 4030	781-356-0657
Braintree High School	Diane Bulman, R.N. R.N. Brenna Coughlin, RN R.N.	781-848-4000 ext. 7031 781-848-4000 ext. 7030 781-848-4000 ext. 9	781-843-6921
Physician Consultant	Philip Nedelman, M.D.	781-249-1127	Updated June 2018

Braintree Public Schools Medical History

(To be completed by Parent/Guardian)

Name ______________________________ Grade ________ School ________________
First Middle Last

Address ____ Telephone ______________

Transfer from ____________________________________ Today's Date ____________

Date of Birth _________________________ City/State of Birth ____________________

Parent/Guardian Name ___________________ Relationship _________________________

Email ______________________________

Parent/Guardian Name ___________________ Relationship _________________________

Email ______________________________

Number of other children in family ________ Primary language spoken in home ____________

Name ______________ Birth Date ________ Name ______________ Birth Date ________

Name ______________ Birth Date ________ Name ______________ Birth Date ________

Child lives with: ☐ Parent/Guardian ____________ ☐ Other _________________________

Were there any complications at birth? ☐ Yes ☐ No If yes, please describe:________________

____

Has this child had any of the following: If yes, please explain:

☐ Asthma ____________________________
☐ Allergies (list) ______________________
Epi-Pen Used ☐ Yes ☐ No
☐ Heart Problems _______________________
☐ Kidney Problems ______________________
☐ Diabetes ____________________________
☐ Seizures ____________________________
☐ Fractures/location/date ________________
☐ Hepatitis ____________________________
☐ Scoliosis ____________________________
☐ Hearing Problems ________ ☐ Hearing Aides
☐ Vision Problems ________ ☐ Glasses ☐ Contacts
☐ Other:____

Does this child take any medication? If yes, please state medication and reason _______________

____

Can this student participate in a full Physical Education Program? ☐ Yes ☐ No

If no, explain why ____

Family Physician _________________________ Family Dentist _________________________

I give permission to the school nurse to share the above medical information with school personnel as determined appropriate for my child's health and safety. ☐ Yes ☐ No

Parent/Guardian Signature ____

Please return completed form to the School Nurse

Updated April 27, 2018

MASSACHUSETTS SCHOOL HEALTH RECORD

Health Care Provider's Examination

Name ____ ☐ Male ☐ Female Date of Birth:______________________

Medical History ____

____

Pertinent Family History

Current Health Issues

Y **N**

☐ ☐ Allergies: Please list: Medications ____________________ Food _______________ Other _____________

History of Anaphylaxis to __________________ Epi-Pen®: ☐ Yes ☐ No

☐ ☐ Asthma: Asthma Action Plan ☐ Yes ☐ No (*Please attach*)

☐ ☐ Diabetes: ☐ Type I ☐ Type II

☐ ☐ Seizure disorder: ____

☐ ☐ Other (*Please specify*) ____

Current Medications (if relevant to the student's health and safety) *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

Physical Examination **Date of Examination:**________________________

Hgt: ________(_____%) Wgt:_________(_____%) BMI: _________(_____%) BP: ________

(Check = Normal / If abnormal, please describe.)

☐ General _______________ ☐ Lungs _________________ ☐ Extremities _____________

☐ Skin _________________ ☐ Heart __________________ ☐ Neurologic _____________

☐ HEENT _______________ ☐ Abdomen _______________ ☐ Other __________________

☐ Dental/Oral ___________ ☐ Genitalia ________________

Screening:

	(Pass)	(Fail)		(Pass)	(Fail)		(Pass)	(Fail)
Vision: Right Eye	☐	☐	Hearing: Right Ear	☐	☐	Postural Screening:	☐	☐
Left Eye	☐	☐	Left Ear	☐	☐	(Scoliosis/Kyphosis/Lordosis)		
Stereopsis	☐	☐						

Laboratory Results: ☐ Lead _______ Date _______________ ☐ Other____________________________________

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):

TB Test Type: ☐ TST ☐ IGRA Date: ____________ Result: ☐Positive ☐Negative ☐Indeterminate/Borderline

Referred for evaluation to: ____ Date:_______ ☐ Low risk (no TB test done)

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:____

☐ Yes ☐ No **This student may participate fully in the school program, including physical education and competitive sports.**

If no, please list restrictions:____

☐ Yes ☐ No **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record**.

____ ________ ______________________________________

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

____ ________

Group Practice Telephone

____

Address City State Zip Code

Please attach additional information as needed for the health and safety of the student. *MDPH 2015*

CERTIFICATE OF IMMUNIZATION

Name: **Date of Birth:** / / **Sex:** M F

Please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date	Vaccine Type	Vaccine		Date	Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	1			**Rotavirus** (e.g., RV5: 3-dose series, RV1: 2-dose series)	1		
	2				2		
	3				3		
	4			**Measles, Mumps, Rubella** (e.g., MMR, MMRV)	1		
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1				2		
	2			**Varicella** (e.g., Var, MMRV)	1		
	3				2		
	4			**Meningococcal** Conjugate (MCV4), Hib-MenCY or Polysaccharide (MPSV4)	1		
	5				2		
	6			**Seasonal Influenza** Inactivated IIV3, IIV4, ccIIV3-IM, IIV3-ID, IIV3-HD RIV3-IM Live Attenuated LAIV, LAIV4	1		
	7				2		
***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib, Hib-MenCY)	1				3		
	2				4		
	3			**2009 H1N1 Influenza** Inactivated or Live	1		
	4				2		
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1			**Pneumococcal Polysaccharide** (PPSV23)	1		
	2				2		
	3			**Hepatitis A** (e.g., HepA, HepA-HepB)	1		
	4				2		
	5			**Human Papillomavirus** (HPV4, HPV2)	1		
Pneumococcal Conjugate (PCV7, PCV13)	1				2		
	2				3		
	3			**Other:**			
	4						

Serologic Proof of Immunity		**Check One**	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		

* Must also check Chickenpox History box.

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name *(please print)*: **Date:** / /

Signature:

Facility name: