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	☐	☐	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	☐	☐	Describe: _____
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: _____ (____%) BP: _____

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

☐ General _____ ☐ Lungs _____ ☐ Extremities _____

☐ Skin _____ ☐ Heart _____ ☐ Neurologic _____

☐ HEENT _____ ☐ Abdomen _____ ☐ Other _____

☐ Dental/Oral _____ ☐ Genitalia _____

Screening

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

The entire examination was normal: ☐

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.**

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendation for further evaluation or treatment for:

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician _____ Date _____

Signature of Physician _____ Date _____