REGISTRATION CHECKLIST

✓ CBRSD Registration Form and Home Language Form (Online)

✓ Birth Certificate (Attach document, mail, or bring to school)

✓ Massachusetts School Health Records: (a) Your doctor will fill out this form when you arrange a physical for your child. The Massachusetts Health Record, when completed, should be returned to the school at which your child is registered. (b) At the time of registration, if your child has not yet had his/her physical exam, please inform us of the date of your appointment and the name of the doctor. State law requires that all children have a physical exam and completed immunizations before entering kindergarten. The immunization, month and year of each immunization must be recorded on the form by your physician. (Attach document, mail, or bring to school)

✓ Proof of residency, any of the following documents are considered proof: utility bill, rental agreement, purchase and sale agreement, etc. (Attach a document, mail, or bring to school)

CERTIFICATE OF IMMUNIZATION

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

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

Vaccine		Date	Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	1		
	2		
	3		
	4		
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1		
	2		
	3		
	4		
	5		
	6		
	7		
	8		
***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib, Hib-MenCY)	1		
	2		
	3		
	4		
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1		
	2		
	3		
	4		
	5		
Pneumococcal Conjugate (PCV13, PCV7)	1		
	2		
	3		
	4		
Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1		
	2		
	3		

Vaccine		Date	Vaccine Type
Measles, Mumps, Rubella (e.g., MMR, MMRV)	1		
	2		
Varicella (Var, MMRV)	1		
	2		
Meningococcal Quadrivalent MenACWY-Conjugate (MCV4) or Polysaccharide (MPSV4)	1		
	2		
Meningococcal Serogroup B (Men B) MenB-FHbp MenB-4C	1		
	2		
	3		
Seasonal Influenza Inactivated IIV4, IIV4-ID, IIV3, IIV3-ID, IIV3-HD, RIV3-IM, ccIIV3-IM Live Attenuated LAIV, LAIV4 (quadrivalent)	1		
	2		
	3		
	4		
	5		
	6		
	7		
2009 H1N1 Influenza Inactivated or Live	1		
	2		
Pneumococcal Polysaccharide (PPSV23)	1		
	2		
Hepatitis A (HepA, HepA-HepB)	1		
	2		
Human Papillomavirus (9vHPV, 4vHPV, 2vHPV)	1		
	2		
	3		
Zoster (shingles)	1		
Other:	1		
	2		

Please see next page ➡

CERTIFICATE OF IMMUNIZATION (continued)

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:

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

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: _____

☐Y ☐N **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:** _____

☐ Y ☐ N **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 08/15/13*

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF COMMUNICABLE AND VENEREAL DISEASES
600 Washington Street
Boston, Massachusetts 02111

SCHOOL IMMUNIZATION LAW

CHAPTER 76, SECTION 15 OF THE GENERAL LAWS OF MASSACHUSETTS

Section 15.

No child shall, except as hereinafter provided, be admitted to school except upon presentation of a physician's certificate that the child has been successfully immunized against diphtheria, pertussis, tetanus, measles and poliomyelitis and such other communicable diseases as may be specified from time to time by the department of public health.

A child shall be admitted to school upon certification by a physician that he has personally examined such child and that in his opinion the physical condition of the child is such that his health would be endangered by such vaccination or by any of such immunizations. Such certification shall be submitted at the beginning of each school year to the physician in charge of the school health program. If the physician in charge of the school health program does not agree with the opinion of the child's physician, the matter shall be referred to the department of public health, whose decision will be final.

In the absence of an emergency or epidemic of disease declared by the department of public health, no child whose parent or guardian states in writing that vaccination or immunization conflicts with his sincere religious beliefs shall be required to present said physician's certificate in order to be admitted to school.