CERTIFICATE OF IMMUNIZATION

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

If combination vaccine is administered, 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**	1	
	2			2	
	3			3	
	4		**Measles, Mumps, Rubella** (MMR, MMRV)	1	
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td, Tdap)	1			2	
	2		**Varicella** (Var, MMRV)	1	
	3			2	
	4		**Meningococcal** Conjugate (MCV4) or Polysaccharide (MPSV4)	1	
	5			2	
	6		**Influenza** Inactivated (Intramuscular) or Live (Intranasal)	1	
	7			2	
***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib)	1			3	
	2			4	
	3			5	
	4			6	
Polio (e.g., IPV, DTaP-HepB-IPV)	1		**Pneumococcal Polysaccharide** (PPV23)	1	
	2			2	
	3		**Hepatitis A** (HepA, HepA-HepB)	1	
	4			2	
	5		**Human Papillomavirus** (HPV)	1	
Pneumococcal Conjugate (PCV7)	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:

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):
Date of PPD: ____; Results: ____mm.
Referred for evaluation to: _____ ☐ Low risk (no PPD 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 12/14/04*

GLENBROOK MIDDLE SCHOOL
LONGMEADOW PUBLIC SCHOOLS
Prescription and Non Prescription Medication Form

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

The following is to be completed by parent/guardian

School _____ Grade _____

Student's Name _____ Sex _____ Date of Birth _____
Last First

I request that my son/daughter be assisted in taking the medication(s) described below at school by authorized persons or permitted to medicate herself/himself as also authorized by me and my physician (see below).

_____ _____ _____ _____
Signature Parent/Guardian **Home Phone** **Emergency Phone** **Date**

****

The following is to be completed by the Physician

Diagnosis for which medication is given: _____

Name of Medication: _____

Form _____ Dosage _____ Time of Medication if daily _____

If medication is to be given prn describe indications: _____

_____

How soon can it be repeated _____ Can student medicate self? Yes____ No ____

List significant side effects: _____

Date to start _____ Date to stop _____

Other information _____

Physician/Nurse Practitioner Signature _____ **Date** _____

Print Physician/Nurse Practitioner Name _____

Telephone # _____