The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
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PAUL J. COTE, JR.
COMMISSIONER

TO: School Nurse and School Physicians

FROM: Anne H. Sheetz
Director of School Health Services

DATE: April 20, 2005

SUBJ: Massachusetts School Health Record

MEMORANDUM

Each student in the Commonwealth's schools is required to have a school health record. During the past year, the Massachusetts Department of Public Health has collaborated with school nurses to update the existing face-sheet of the school health record. The goal of this process was to identify information needed by the school to protect the health and safety of the student and to meet certain legal requirements. Another goal was to create a single-page document for ease of implementation.

Attached is the revised School Health Record Face-sheet. When completed, this form, ***with the student's complete record/certificate of immunizations*** will become part of the student's school health record. We would suggest that you consider copying the certificate of immunizations on the back of the School Health Record to ensure that it is included as part of this record. Or, you may wish to attach the certificate of immunizations to the face-sheet.

If a school district wishes to use a different form or format, this is acceptable, provided the content of the Massachusetts School Health Record Face-Sheet is included. School districts may also wish to add more information pertinent to their student population.

We hope this revised Massachusetts School Health Record form proves useful to you. Thank you.

MASSACHUSETTS SCHOOL HEALTH RECORD

School _____ **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

(1) Parent/Guardian:		**(2) Parent/Guardian:**
Name & Mailing Address if different:		Name & Mailing Address if different:
Phone Numbers		Phone Numbers
Home		Home
Work		Work
Cell		Cell
FAX		FAX

Emergency Contact Information

(1) Emergency Contact	**(2) Emergency Contact**
Name & Phone Number:	Name & Phone Number:
Primary Care Provider	**Dental Care Provider**
Name:	Name:
Phone Number:	Phone Number:
Health Insurance: **Allergies:**	

Primary Custody (if not joint) _____

General				**Growth**			**Vision**						**Hearing**				**Postural**	
							Preschool Certificate Yes ☐ No ☐											
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**
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		10																
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		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.)

From: https://www.mass.gov/files/documents/2016/07/rv/ma-school-health-record.pdf