MASSACHUSETTS SCHOOL HEALTH RECORD
Health Care Provider's Examination

Name Lauren Govostes ☒ Male ☐ Female **Date of Birth:** 9-25-02

Medical History 4½ yrs

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:** 2/26/07

Hgt: 42 (75%) Wgt: 44 (90%) BMI: 17.5 (92%) BP: 80/50

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

☐ General _____ ☐ Lungs _____ ☐ Extremities _____
☐ Skin _____ ☐ Heart _____ ☐ Neurologic _____
☐ HEENT _____ ☐ Abdomen _____ ☐ Other _____
☐ Dental/Oral _____ ☐ Genitalia _____

Screening:

	(Pass)	(Fail)	
Vision: Right Eye	☒	☐	20/25
Left Eye	☒	☐	
Stereopsis	☒	☐	

	(Pass)	(Fail)	
Hearing: Right Ear	☐	☐	could not cooperate
Left Ear	☐	☐	

Postural Screening (Scoliosis/Kyphosis/Lordosis): (Pass) ☒ (Fail) ☐

Laboratory Results: ☒ Lead _____ Date _____ ☐ Other _____

The entire examination was normal: ☒ pending last Pb 9/03 @ age 1

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 2/26/07

David A Bross MD
Please print name of Examiner.

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Address City State Zip Code

Please attach additional information as needed for the health and safety of the student. MDPH 12/14/04