

1. AUTHORIZATION & CONSENT FORM

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child (full name) _____. However, if I cannot be reached, I hereby authorize NEHA to transport my child to the _____ Hospital (or Children's Hospital) and to secure for my child the necessary medical treatment.

I understand the teachers in the preschool are trained in Basic First Aid/CPR and I authorize them to give my child aid when appropriate.

Date

Parent Signature

2. Please sign and date the section below, even if no one else besides you will be picking up your child, so we know that you read this section, and didn't omit it accidentally.

I authorize New England Hebrew Academy to release my child to the following persons (other than parents):

NAME: _____ TEL. NO. _____

RELATIONSHIP: _____

NAME: _____ TEL. NO. _____

RELATIONSHIP: _____

NAME: _____ TEL. NO. _____

RELATIONSHIP: _____

Date

Parent Signature

3. Allergies-Yes (list) _____ No _____

EpiPen- Yes _____ No _____

4. Emergency Contact Information

Name & relationship to child- _____

Phone number- _____

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.)

<input type="checkbox"/> General _____	<input type="checkbox"/> Lungs _____	<input type="checkbox"/> Extremities _____
<input type="checkbox"/> Skin _____	<input type="checkbox"/> Heart _____	<input type="checkbox"/> Neurologic _____
<input type="checkbox"/> HEENT _____	<input type="checkbox"/> Abdomen _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dental/Oral _____	<input type="checkbox"/> Genitalia _____	

Screening:

(Pass) (Fail)
Vision: Right Eye
Left Eye
Stereopsis

(Pass) (Fail)
Hearing: Right Ear
Left Ear

(Pass) (Fail)
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:

<input type="checkbox"/> Vision	<input type="checkbox"/> Hearing	<input type="checkbox"/> Speech/Language	<input type="checkbox"/> Fine/Gross Motor Deficit
<input type="checkbox"/> Emotional/Social	<input type="checkbox"/> Behavior	<input type="checkbox"/> 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

CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: / /

Sex: M F

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 (e.g., RV5: 3-dose series, RV1: 2-dose series)	1		
	2				2		
	3				3		
	4						
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1			Measles, Mumps, Rubella (e.g., MMR, MMRV)	1		
	2				2		
	3			Varicella (e.g., Var, MMRV)	1		
	4				2		
	5			Meningococcal Conjugate (MCV4) or Polysaccharide (MPSV4)	1		
	6				2		
	7			Seasonal Influenza Inactivated (Intramuscular) or Live (Intranasal)	1		
Haemophilus influenzae type b (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib)	1				2		
	2				3		
	3				4		
	4			H1N1 Influenza Inactivated (Intramuscular) or Live (Intranasal)	1		
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1				2		
	2			Pneumococcal Polysaccharide (PPSV23)	1		
	3				2		
	4			Hepatitis A (e.g., HepA, HepA-HepB)	1		
	5				2		
Pneumococcal Conjugate (e.g., PCV7, PCV13)	1			Human Papillomavirus (e.g., HPV quadrivalent, HPV bivalent,)	1		
	2				2		
	3				3		
	4			Other:			

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
<input type="checkbox"/> Check the box if this person has a physician-certified reliable history of chickenpox.
Reliable history may be based on:
<ul style="list-style-type: none"> • 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: _____