NORTHEAST METRO TECH HIGH SCHOOL HEALTH OFFICE
781-246-0810, EXT 1624/1620 – FAX (781) 246-9323

IMPORTANT
PHYSICIAN PACKET

THIS PACKET MUST BE RETURNED TO:

NORTHEAST METRO TECH HEALTH OFFICE
100 HEMLOCK ROAD
WAKEFIELD, MA 01880

Dear Parent/Guardian:

Massachusetts law requires that all students have a school health examination. At Northeast Metropolitan Regional Vocational School, an up to date physical examination is required of all entering students. If your child has a physical scheduled after the first day of school, please notify the Nurses' Office of the scheduled date as soon as possible at (781) 246- 0810, ext. 1624 or 1620.

Also, a yearly physical exam is required for all students participating in athletic programs.

Massachusetts School Immunization Law, Chapter 76, Section 15 requires that all students enrolled in public and private school be fully immunized. Please be sure that all immunizations are up to date. A tetanus vaccination is effective for 10 years. No student will be allowed to enter Northeast Metro Tech High School if we have not received a copy of the required immunizations. Please have your physician fill out your child's physical examination and immunization record.

Also, the attached medication order form must be filled out by your physician ONLY if your child will be taking medication in the school setting.

Please include anything pertinent concerning the student's state of health, physical or mental growth and development, and/or nutrition. Include any recommendations for modification of the school program which you think might be required to meet his/her needs.

We would appreciate notification from you during the school year concerning any change in the health status of your child which may affect his/her performance in school.

Information which you submit will be regarded as confidential.

Properly filled out form may be mailed to:
Northeast Metro Tech High School
Health Office
l00 Hemlock Road
Wakefield, MA 01880

Enclosure:
DH/ds

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) (Pass) (Fail)

Vision: Right Eye ☐ ☐ Hearing: Right Ear ☐ ☐

Postural Screening: ☐ ☐

Left Eye ☐ ☐ Left Ear ☐ ☐

(Scoliosis/Kyphosis/Lordosis)

Stereopsis ☐ ☐

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 COMPLETE ATTACHED FORMS IF MEDICATION MUST BE GIVEN AT SCHOOL

Massachusetts Department of Public Health : CERTIFICATE OF IMMUNIZATION

Name: *Date of Birth:* **Sex: ☐female ☐male**

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)	1		***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1			4	
	2		**Measles, Mumps, Rubella** (MMR)	1	
	3			2	
	4		**Varicella** (Var)	1	
	5			2	
	6		**Hepatitis A** (HepA)	1	
	7			2	
Polio (e.g., IPV, DTaP-HepB-IPV)	1		**Pneumococcal Polysaccharide** (PPV23)	1	
	2			2	
	3		**Influenza** Inactivated (Intramuscular) or Live (Intranasal)	1	
	4			2	
Pneumococcal Conjugate (PCV7)	1			3	
	2		**Other:**		
	3				
	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**

NORTHEAST METROPOLITAN REGIONAL VOCATIONAL SCHOOL
MEDICATION POLICY

Dear Parent/Guardian:

We would like to inform you about the policies that have been put in place to ensure the health and safety of children needing medication during the school day. Our school district requires that the following forms be completed and kept in the student's health file before we can distribute any medication to the student during the school day. Medication must be brought to school by a parent/guardian or parent-designated adult (18 years of age). All prescription medication must be in a pharmacy-labeled container with the prescription label intact. No more than a thirty-day supply of the medication should be supplied to the school.

Prescription medications

THESE FORMS MUST BE RENEWED AT THE START OF EACH ACADEMIC YEAR

1. **Signed Parent/Guardian Consent Form**
Please complete the enclosed Consent Form giving permission to the school nurse to administer medication.

2. **Signed Physician Medication Order Form**
The written medication order form should be taken to your child's licensed prescriber (physician, nurse practitioner) for completion and returned to the school nurse. **This medication order can also be faxed to the school nurse (781) 246-4919.**

Note: **The labeled prescription bottle is adequate documentation for ten (10) days administration of a medication. If the medication is to be administered longer than ten (10) days, a written documentation from the physician or designated assistant is needed. The medication must be accompanied by written permission from the parent before administration. The state policy mandates that children may not self-medicate, except under certain conditions such as inhalers. If your child is using an inhaler in school, please complete the form allowing him/her to self-medicate.**

Non-Prescription Medications
All non-prescription medications require written documentation by a physician or designated assistant and written parent permission. The exceptions are Tylenol (Acetaminophen 325 mg. 1-2 tablets) or Advil (Ibuprofen 200mg. 1-2 tablets) which may be given *under the order of the school physician Dr. David Roston.* However, written parent permission is needed to dispense these medications. The school provides Tylenol and Ibuprofen in the Nurses' Office.

Any non-prescription medications sent to school must be brought in and picked up by an adult (18 years of age).

When your child needs a medicine to be given during the school day, please follow these policies quickly so we can begin to administer the medicine as soon as possible.

If at any time during the school year you have any questions or concerns, please feel free to contact the Health Office (781) 246-0810, Extension 1624 or 1620.

Northeast Metro Tech High School
Telephone: 781-246-0810, ext 1624/1620 - Fax: (781) 246-4919

Medication Order for Physician and Parent

PHYSICIAN'S ORDER:

Name of Student: _____ DOB: _____

Medication: _____ Dosage: _____

Route of administration _____ Frequency_____

Time(s) of administration: _____ _____

(Please note: Whenever possible, medication should be scheduled at times other than schools hours).

Diagnosis: (if not confidential)
_____

Specific directions/instructions for administration:
_____
_____

Date of Order _____ Discontinuation Date :

_____
Physician's/Licensed Prescriber Signature Date

_____
Address Telephone

(PARENT/GUARDIAN SECTION BELOW)

TO BE COMPLETED BY PARENT /GUARDIAN:

Student's Name: (print)_____Grade: _____

Parent/Guardian Telephone Number (s): Home _____Cell/Work _____

1. I give permission for the school nurse or designee to administer the above medication prescribed.

2. This medication is being taken for:
_____

3. List any other medications your child takes:
_____
_____

4.Physician's Name (please print): _____

5. I give permission to the school nurse to inform appropriate school personnel relative to the prescribed medicine administered to my child: ____Yes _____ No

Please note: I understand that I may retrieve the medication from the school nurse at any time and that the medication will be destroyed if it is not picked up within one week following the termination of the order.

Signature of parent/guardian: _____
Date: _____