

EXHIBIT 2-18

**MASSACHUSETTS SCHOOL HEALTH RECORD
PRIVATE PHYSICIAN'S EXAMINATION**

Child's Name _____ Sex _____ Birth Date _____

Address _____ School _____

IMMUNIZATION	Date	IMMUNIZATION	Date	IMMUNIZATION	Date	SPECIAL TESTS	
DTP (Diphtheria Tetanus Pertussis)		POLIO Oral Trivalent (TOPV)		MMR (combined)		TUBERCULIN TEST	
				TETANUS TOXOID		Results	Date
				OTHER IMMUNIZATION			
				<i>Hep B Series</i>			
Td (Tetanus Diphtheria) Adult Type		MEASLES		<i>Varicella Hx</i>		LEAD TEST	
		MUMPS		<i>Vaccin</i>			
		RUBELLA					

MEDICAL HISTORY (give dates)

Accidents	Ear Infections	Measles	Scarlet Fever
Allergy	Encephalitis	Meningitis	Strep. Throat
Chicken Pox	Rubella	Mumps	Tonsillitis
Congenital Anomaly	Heart Disease	Operations	Tuberculosis
Convulsions	Hernia	Poliomyelitis	Whooping Cough
Diabetes	Kidney Disease	Rheumatic Fever	Other

PERTINENT FAMILY MEDICAL HISTORY

SUMMARY OF SIGNIFICANT TREATMENT PROGRAMS INCLUDING CURRENT MEDICATIONS, AND SUGGESTIONS FOR PROGRAM ADJUSTMENT IF INDICATED

Please check here if CLEARED for SPORTS

RECORD APPROVED BY DEPARTMENT OF EDUCATION AND THE MASS. DEPT. OF PUBLIC HEALTH

NOTE: Clip or staple this record to cumulative school health record.
FORM PH-M-18 (Rev. 1983)-350M-6/84-178653

PRIVATE PHYSICIAN'S EXAMINATION

In order to ensure a quality standard of complete examination for each school child, please record your findings after each item

(O) normal (X) abnormal

DATE	Comment	Treatment
Age BP/..... PulseHgt. Wgt.		
Physical Development		
Nutritional Status		
Skin		
Eyes sclera pupils		
light & distance: r. l.		
glasses		
Ears canals: r. l.		
drums: r. l.		
Nose septum turbinates		
Mouth lips tongue pharynx		
Teeth gingiva		
Neck mobility lymph nodes thyroid		
Throat shape symmetry		
Lungs		
Heart rate rhythm murmur		
Abdomen liver spleen		
hernias		
Ano-Genital anus penis labia		
testicles: r. l.		
Tanner stage:		
Spine		
Lower Extremities range of motion		
development strength		
Upper Extremities range of motion		
development strength		
Cranial Nerve I-XII		
Gait		
Coordination		
Lab Tests		
Hgb/Hct		
Other:		

Address _____ Date _____ Signature _____