

School Name & Address:

Health Care Provider Name and Address:

STATE OF RHODE ISLAND SCHOOL PHYSICAL FORM

Phone:

This form may substitute for any district-issued form. All districts must accept this form. General health examinations shall be documented in a standardized format with one copy available from the Rhode Island Department of Health or in any such format that captures the same fields of information (R16-21SCHO Section 8.4)

Student Name: Last	First	Middle	Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>
Address: Street	Apt #	City	State	Zip Code
				Home Phone

PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript). The requested information is in accordance with the State of Rhode Island Rules and Regulations for: Immunization and Testing for Communicable Disease, School Health Programs, and Lead Poisoning Prevention. Website: www.rules.state.ri.us/rules

IMMUNIZATIONS					
Hepatitis B	___/___/___	___/___/___	___/___/___		
Diphtheria-Tetanus- Pertussis DTP/DTaP	___/___/___ Check <input type="checkbox"/> if DT	___/___/___ Check <input type="checkbox"/> if DT	___/___/___ Check <input type="checkbox"/> if DT	___/___/___ Check <input type="checkbox"/> if DT	___/___/___ Check <input type="checkbox"/> if DT
Pneumococcal Conjugate PCV	___/___/___	___/___/___	___/___/___	___/___/___	
Polio	___/___/___ <input type="checkbox"/> IPV or <input type="checkbox"/> OPV	___/___/___ <input type="checkbox"/> IPV or <input type="checkbox"/> OPV	___/___/___ <input type="checkbox"/> IPV or <input type="checkbox"/> OPV	___/___/___ <input type="checkbox"/> IPV or <input type="checkbox"/> OPV	
Haemophilus Influenzae Type B Hib	___/___/___	___/___/___	___/___/___	___/___/___	
Measles-Mumps-Rubella MMR	___/___/___	___/___/___			
Varicella	___/___/___	___/___/___	<input type="checkbox"/> Student has history of varicella disease		
Tetanus-Diphtheria-Pertussis Tdap	___/___/___				
Tetanus-Diphtheria Td	___/___/___	___/___/___	___/___/___		
Meningococcal	___/___/___	___/___/___			

Immunization Exemption: Medical Religious

Hepatitis B
 DTaP
 IPV
 Hib
 PCV
 MMR
 Varicella
 Td/Tdap

PHYSICAL EXAMINATION

Date of PE ___/___/___ Height _____ Weight _____ BP _____

Please note any health problem, chronic health condition, or disability that may affect behavior or health at school:

ASTHMA: No Yes DIABETES: No Yes OTHER: _____

Significant Systems Findings: _____

ALLERGIES: No Yes (Please explain) _____ EPINEPHRINE AUTO-INJECTOR REQUIRED: No Yes

Treatment Plan: _____

MEDICATION (REQUIRED AT SCHOOL): No Yes (Please list) _____

Other medication(s) that may affect behavior or health at school: _____

RESTRICTIONS: Can participate in physical education: Fully With limitation _____

Can participate in sports: Fully With limitation _____

LEAD SCREENING (Required for children < 6 years of age only) Student is in compliance with lead screening requirements: Yes <input type="checkbox"/> No <input type="checkbox"/>	VISION SCREENING (Required for children entering kindergarten) <input type="checkbox"/> Pass <input type="checkbox"/> Failed and referred for comprehensive exam <input type="checkbox"/> Not screened and referred for comprehensive exam	SCOLIOSIS SCREENING Yes <input type="checkbox"/> No <input type="checkbox"/>
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TUBERCULOSIS (If required by school district) Date of TB test:	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
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HEALTH CARE PROVIDER SIGNATURE: _____ DATE: _____

PRINT NAME: _____