

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
Address: Street	Apt #	City	State	Zip Code
			Home Phone	

PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript).

IMMUNIZATIONS	Please enter dates in MM/DD/YYYY format			
Hepatitis B				
Diphtheria-Tetanus-Pertussis DTaP < 7 years				
Pneumococcal Conjugate PCV				
Polio				
Haemophilus Influenzae Type B Hib				
Measles-Mumps-Rubella MMR				
Varicella			<input type="checkbox"/> Student has history of varicella disease	
Tetanus-Diphtheria-Pertussis Tdap/Td > 7 years				
Rotavirus				
Hepatitis A				
Meningococcal				
HPV				
Influenza				

Medical Exemption:

- Hep B
 DTaP
 PCV
 Polio
 Hib
 MMR
 Varicella
 Td/Tdap
 Rotavirus
 Hep A
 Mening
 HPV
 Influenza

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 If yes, complete an [Asthma Action Plan](http://www.health.ri.gov/publications/actionplans/2012Asthma.pdf) (www.health.ri.gov/publications/actionplans/2012Asthma.pdf)
- ALLERGIES: No Yes (Please explain) _____ EPINEPHRINE AUTO-INJECTOR REQUIRED: No Yes
If student has a severe allergy (food, insect, other) complete a [Food Allergy & Anaphylaxis Emergency Care Plan](http://www.foodallergy.org/document.doc?id=234) (www.foodallergy.org/document.doc?id=234)
- DIABETES: No Yes If yes, complete a [Physicians Order Form For Students With Diabetes](http://www.health.ri.gov/forms/school/PhysicianOrdersForStudentsWithDiabetes.pdf) (www.health.ri.gov/forms/school/PhysicianOrdersForStudentsWithDiabetes.pdf)
- OTHER: _____

Treatment Plan: _____

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

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

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

LEAD SCREENING (Required for children < 6 years old) Student is in compliance with lead screening requirements: Yes <input type="checkbox"/> No <input type="checkbox"/>	SCOLIOSIS SCREENING Yes <input type="checkbox"/> No <input type="checkbox"/>	VISION SCREENING (Children entering Kindergarten) <input type="checkbox"/> Passed Screening <input type="checkbox"/> Screened & referred for comprehensive exam <input type="checkbox"/> Referred for comprehensive exam, but not screened
TUBERCULOSIS (If required by school district) Date of TB test: _____		Screening / Referral Date: _____ Comprehensive Exam Date: _____

HEALTH CARE PROVIDER SIGNATURE: _____ DATE: _____

PRINT NAME: _____