

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 | 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 | | | | | |
| 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 | <input type="checkbox"/> Td or <input type="checkbox"/> Tdap | <input type="checkbox"/> Td or <input type="checkbox"/> Tdap | <input type="checkbox"/> Td or <input type="checkbox"/> Tdap | | |
| Rotavirus | | | | | |
| Hepatitis A | | | | | |
| Meningococcal | | | | | |

Immunization Exemption: Medical Religious

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

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 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 and referred for comprehensive exam <input type="checkbox"/> Referred for comprehensive exam, but not screened Screening / Referral Date: _____ Comprehensive Exam Date: _____ |
| TUBERCULOSIS (If required by school district) Date of TB test: _____ | | |

HEALTH CARE PROVIDER SIGNATURE: _____ DATE: _____

PRINT NAME: _____