

School Name & Address:

Grade: \_\_\_\_\_



STATE OF RHODE ISLAND  
SCHOOL PHYSICAL FORM

Health Care Provider Name and Address:

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 ( [www.health.ri.gov/publications/actionplans/2012Asthma.pdf](http://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 ( [www.foodallergy.org/document.doc?id=234](http://www.foodallergy.org/document.doc?id=234) )
- DIABETES: No  Yes  If yes, complete a Physicians Order Form For Students With Diabetes ( [www.health.ri.gov/forms/school/PhysicianOrdersForStudentsWithDiabetes.pdf](http://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: \_\_\_\_\_

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

HEALTH CARE PROVIDER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_