School Name & Address:		Health Care Provider Name and Address:
Grade: _____		Phone:

STATE OF RHODE ISLAND
SCHOOL PHYSICAL FORM

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			☐ **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:

1. ASTHMA: No☐ Yes☐ If yes, complete an *Asthma Action Plan* (www.health.ri.gov/publications/actionplans/2012Asthma.pdf)
2. 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)
3. DIABETES: No☐ Yes☐ If yes, complete a *Physicians Order Form For Students With Diabetes* (www.health.ri.gov/forms/school/PhysicianOrdersForStudentsWithDiabetes.pdf)
4. 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☐ No☐	**SCOLIOSIS SCREENING** Yes☐ No☐	**VISION SCREENING (Children entering Kindergarten)** ☐Passed Screening ☐Screened & referred for comprehensive exam ☐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: _____