School Name & Address:

Health Care Provider Name and Address:

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 DTP/DTaP	Check ☐ if DT	Check ☐ if DT	Check ☐ if DT	Check ☐ if DT	Check ☐ if DT
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	Check ☐ if Td	Check ☐ if Td	Check ☐ if Td		
Rotavirus					
Hepatitis A					
Meningococcal					
HPV					

Immunization Exemption: ☐ **Medical** ☐ **Religious**

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

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)	SCOLIOSIS SCREENING	VISION SCREENING (Children entering Kindergarten)
Student is in compliance with lead screening requirements: Yes ☐ No ☐	Yes ☐ No ☐	☐ Passed screening ☐ Screened and referred for comprehensive exam ☐ Referred for comprehensive exam, but not screened
TUBERCULOSIS (If required by school district) **Date of TB test:**		**Screening Date:** **Comprehensive Exam Date:**

HEALTH CARE PROVIDER SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____

Revised 8-09