

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 DTP/DTaP	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	Check <input type="checkbox"/> if Td	Check <input type="checkbox"/> if Td	Check <input type="checkbox"/> 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) 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 Date: _____ Comprehensive Exam Date: _____
TUBERCULOSIS (If required by school district) Date of TB test: _____		

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

DATE: \_\_\_\_\_

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