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 M ☐ F ☐

Address: Street	Apt #	City	State	Zip Code	Home Phone

PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript). The requested information is in accordance with the State of Rhode Island *Rules and Regulations for: Immunization and Testing for Communicable Disease, School Health Programs, and Lead Poisoning Prevention*. Website: www.rules.state.ri.us/rules

IMMUNIZATIONS

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	___/___/___ ☐ IPV or ☐ OPV	___/___/___ ☐ IPV or ☐ OPV	___/___/___ ☐ IPV or ☐ OPV	___/___/___ ☐ IPV or ☐ OPV	
Haemophilus Influenzae Type B Hib	___/___/___	___/___/___	___/___/___	___/___/___	
Measles-Mumps-Rubella MMR	___/___/___	___/___/___			
Varicella	___/___/___	___/___/___	☐ Student has history of varicella disease		
Tetanus-Diphtheria-Pertussis Tdap	___/___/___				
Tetanus-Diphtheria Td	___/___/___	___/___/___	___/___/___		
Meningococcal	___/___/___	___/___/___			

Immunization Exemption: Medical ☐ Religious ☐

☐ Hepatitis B ☐ DTaP ☐ IPV ☐ Hib ☐ PCV ☐ MMR ☐ Varicella ☐ Td/Tdap

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)	VISION SCREENING (Required for children entering kindergarten)	SCOLIOSIS SCREENING
Student is in compliance with lead screening requirements: Yes ☐ No ☐	ACUITY ☐ Pass ☐ Fail ☐ Referred for comprehensive exam STEREOPSIS ☐ Pass ☐ Fail	Yes ☐ No ☐

TUBERCULOSIS (If required by school district) Date of TB test:						
	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___

HEALTH CARE PROVIDER SIGNATURE: _____ DATE: _____

PRINT NAME: _____

Revised 8-06