

|                                                              |                                                                                                                                           |                                                                          |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| <b>School Name &amp; Address:</b><br><br><b>Grade:</b> _____ | <br><b>STATE OF RHODE ISLAND<br/>SCHOOL PHYSICAL FORM</b> | <b>Health Care Provider Name and Address:</b><br><br><b>Phone:</b> _____ |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|

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<br>DTaP < 7 years    |                                         |  |                                                                   |  |  |
| Pneumococcal Conjugate<br>PCV                     |                                         |  |                                                                   |  |  |
| Polio                                             |                                         |  |                                                                   |  |  |
| Haemophilus Influenzae Type B<br>Hib              |                                         |  |                                                                   |  |  |
| Measles-Mumps-Rubella<br>MMR                      |                                         |  |                                                                   |  |  |
| Varicella                                         |                                         |  | <input type="checkbox"/> Student has history of varicella disease |  |  |
| Tetanus-Diphtheria-Pertussis<br>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](http://www.health.ri.gov/publications/actionplans/2012Asthma.pdf) ( [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](http://www.foodallergy.org/document.doc?id=234) ( [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](http://www.health.ri.gov/forms/school/PhysicianOrdersForStudentsWithDiabetes.pdf) ( [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><br>Student is in compliance with lead screening requirements:<br>Yes <input type="checkbox"/> No <input type="checkbox"/> | <b>SCOLIOSIS SCREENING</b><br>Yes <input type="checkbox"/> No <input type="checkbox"/> | <b>VISION SCREENING (Children entering Kindergarten)</b><br><input type="checkbox"/> Passed Screening <input type="checkbox"/> Screened & referred for comprehensive exam<br><input type="checkbox"/> Referred for comprehensive exam, but not screened<br><b>Screening / Referral</b> <b>Comprehensive</b><br><b>Date:</b> <b>Exam Date:</b> |
| <b>TUBERCULOSIS (If required by school district)</b><br>Date of TB test: _____                                                                                                           |                                                                                        |                                                                                                                                                                                                                                                                                                                                               |

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

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