



Meeting Street

believing in the possibilities

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

IMMUNIZATION					
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 Td	___/___/___	___/___/___	___/___/___		
Meningococcal	___/___/___	___/___/___	Recommended for students who will be entering RI colleges or universities living in dormitories (R23-IMM/COL). May be required in some states.		

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) _____	
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 ___ No ___	

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

Name of Health Care Provider: _____ Phone number: _____

Address: _____

Health Care Provider Signature: _____ Date _____

Problems:
1.
2.
3.
4.
5.
6.

Summary of Significant Treatments at Home and School	
<p>1. Medications/Treatments (Dose, route, frequency)</p> <hr/> <p>Dose/time to be given at school</p> <hr/>	<p style="text-align: center;">Indication</p> <hr/> <p>Relevant side effects, if any. Plan for management.</p> <hr/>
<p>2. Medications/Treatments (Dose, route, frequency)</p> <hr/> <p>Dose/time to be given at school</p> <hr/>	<p style="text-align: center;">Indication</p> <hr/> <p>Relevant side effects, if any. Plan for management.</p> <hr/>
<p>3. Medications/Treatments (Dose, route, frequency)</p> <hr/> <p>Dose/time to be given at school</p> <hr/>	<p style="text-align: center;">Indication</p> <hr/> <p>Relevant side effects, if any. Plan for management.</p> <hr/>
<p>4. Medications/Treatments (Dose, route, frequency)</p> <hr/> <p>Dose/time to be given at school</p> <hr/>	<p style="text-align: center;">Indication</p> <hr/> <p>Relevant side effects, if any. Plan for management.</p> <hr/>

Physician's Signature and Date

Summary of Significant Treatments at Home and School

5. Medications/Treatments
(Dose, route, frequency)

Indication

Dose/time to be given at school

Relevant side effects, if any. Plan for management.

6. Medications/Treatments
(Dose, route, frequency)

Indication

Dose/time to be given at school

Relevant side effects, if any. Plan for management.

7. Medications/Treatments
(Dose, route, frequency)

Indication

Dose/time to be given at school

Relevant side effects, if any. Plan for management.

8. Medications/Treatments
(Dose, route, frequency)

Indication

Dose/time to be given at school

Relevant side effects, if any. Plan for management.

Physician's Signature and Date