MONTESSORI CENTRE
OF BARRINGTON, INC.

STATE OF RHODE ISLAND
SCHOOL PHYSICAL FORM

Health Care Provider Name and Address:

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 DTaP < 7 years					
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 > 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:

1. ASTHMA: No☐ Yes☐ If yes, complete an *Asthma Action Plan* (www.health.ri.gov/publications/actionplans/2012Asthma.pdf)
2. 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* (www.foodallergy.org/document.doc?id=234)
3. DIABETES: No☐ Yes☐ If yes, complete a *Physicians Order Form For Students With Diabetes* (www.health.ri.gov/forms/school/PhysicianOrdersForStudentsWithDiabetes.pdf)
4. 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: _____

LEAD SCREENING (Required for children < 6 years old)	SCOLIOSIS SCREENING	VISION SCREENING (Children entering Kindergarten)
Student is in compliance with lead screening requirements: Yes☐ No☐	Yes☐ No☐	☐ Passed Screening ☐ Screened & referred for comprehensive exam ☐ Referred for comprehensive exam, but not screened
TUBERCULOSIS (If required by school district) Date of TB test:		Screening / Referral Date: Comprehensive Exam Date:

HEALTH CARE PROVIDER SIGNATURE: _____ DATE: _____

PRINT NAME: _____