School Name & Address:
Blessed Sacrament School
240 Regent Avenue
Providence, RI 02908
Grade:

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) Student is in compliance with lead screening requirements: Yes ☐ No ☐	SCOLIOSIS SCREENING Yes ☐ No ☐	VISION SCREENING (Children entering Kindergarten) ☐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: _____

HEALTH HISTORY

Parents, please provide all health information requested in this double sided form.

Providence Schools

STUDENT'S NAME: **DATE OF BIRTH**

_____ _____ _____ _____/_____/_____

Last Name *First Name* *Middle Name* *Month* *Day* *Year*

FAMILY INFORMATION: (please print)

_____ _____ _____ _____

Street Address *Apt Number* *City* *Zip Code*

1._____ _____ ( ) _____ ( ) _____

Last Name *First Name* *Primary Telephone* □ *Other* □ *Work Number*

□ *Mother* □ *Father* □ *Legal Guardian* □ *Other:*_____ *Preferred Language:* _____

EMERGENCY CONTACT INFORMATION (please print)

_____ _____ ( ) _____ ( ) _____

Last Name *First Name* *Primary Telephone* □ *Other* □ *Work Number*

*Relationship to Student:*_____ *Preferred Language:* _____

MEDICAL DOCTOR/CLINIC:

_____ _____ ( ) _____

Physician/Clinic Name *Street/City/State/Zip Code* *Telephone*

MEDICAL HISTORY: *(Please check one response for each of the following diseases or conditions)*

__Yes __No Chickenpox	__Yes __No Tuberculosis	__Yes __No Headaches
__Yes __No German Measles *(Rubella)*	__Yes __No Whooping Cough	__Yes __No Diabetic
__Yes __No Measles	__Yes __No Vision Problems	__Yes __No Frequent sore throat
__Yes __No Mumps	__Yes __No Hearing Problems	__Yes __No Kidney Problems
__Yes __No Pneumonia	__Yes __No Asthma	__Yes __No Heart Problems
__Yes __No Rheumatic Fever	__Yes __No Eczema	__Yes __No Speech Problems
__Yes __No Scarlet Fever	__Yes __No Convulsions	__Yes __No Seasonal Allergies pollen, grass, trees, etc..

Does your child have allergies to □ food or □ medicine? □ **YES** □ **NO**

*If you answered yes, please explain:*_____

_____

Does your child currently suffer from a serious medical condition? □ **YES** □ **NO**

*If you answered yes, please list the medical condition:*_____

_____

Has your child had any surgeries ? _____ □ **Yes** □ **No** **Year:** _____

Has your child had any accidents or injuries? _____ □ **Yes** □ **No** **Year:** _____

Pre-K & K Students has your child had a lead screening? □**Yes** □ **No** **Date:** _____

ATTENTION PARENTS: Do you want to speak with a Nurse/Teacher today? Yes□ No□

Blessed Sacrament School
240 Regent Avenue
Providence, RI 02908

Authorization for Release of School Records

_____

Name of the school your child is transferring from

_____

Street Address

_____

City State Zip Code

PLEASE RELEASE THE OFFICIAL RECORDS OF:

Name of Student:_____

TO: Mr. Christopher Weber, Principal
Blessed Sacrament School
240 Regent Avenue
Providence, RI 02908

Signature of Parent/Guardian:_____

Date:_____

Thank you for your cooperation