HEALTH HISTORY FORM

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 Initial* *Month Day Year*

HOME ADDRESS & TELEPHONE: *(PLEASE PRINT)*

_____ _____ _____ _____
Address *City/Town* *State* *Zip Code*

PARENT/GUARDIAN INFORMATION: *(PLEASE PRINT)*

_____ _____ _____ _____
Name *Home Number* *Work Number* *Mobile Number*

_____ _____ _____ _____
Address *City/Town* *State* *Zip Code*

EMERGENCY CONTACT INFORMATION: *(IF DIFFERENT FROM ABOVE)*

_____ _____ _____ _____
Name *Home Number* *Work Number* *Mobile Number*

_____ _____ _____ _____
Address *City/Town* *State* *Zip Code*

MEDICAL DOCTOR/CLINIC: *(PLEASE PRINT)*

_____ _____
Name *Telephone*

_____ _____ _____ _____
Address *City/Town* *State* *Zip Code*

MEDICAL HISTORY

(Please check off any of the following diseases or conditions the student currently has or has had)

- ☐ Chickenpox
- ☐ German Measles *(Rubella)*
- ☐ Measles
- ☐ Mumps
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Vision Problems
- ☐ Hearing Problems
- ☐ Asthma
- ☐ Eczema
- ☐ Meningitis
- ☐ Headaches
- ☐ Diabetic
- ☐ Frequent sore throats
- ☐ Kidney Problems
- ☐ Heart Problems
- ☐ Speech Problems
- ☐ Other

Allergies *(please list specific allergies)*: _____

_____

Surgeries or Serious Illness: _____ Year: _____

_____

Accidents or Injuries: _____ Year: _____

_____

Has the student a lead screening? If so, please provide the date: _____

Continues on the next page...

OFFICE USE ONLY

Has the parent been interviewed by a Nurse-Teacher during the initial registration process?

Yes ☐ No ☐

MEDICAL HISTORY FORM (CONTINUED)

STUDENT'S NAME: _____ _____ **DATE OF BIRTH:** ____ / ____ / _____
Last Name, First Name *Middle Initial* *Month Day Year*

MEDICATIONS

Is the student currently taking any medications? Yes ☐ No ☐ If yes, please provide the name(s) below

1.- _____ *Dosage:* _____ *How many times a day?* _____
Prescribing physician: _____ *Reason for the medication:* _____
2.- _____ *Dosage:* _____ *How many times a day?* _____
Prescribing physician: _____ *Reason for the medication:* _____

IN THE SPACE BELOW, PLEASE PROVIDE ANY ADDITIONAL HEALTH INFORMATION, WHICH YOU FEEL WOULD BE HELPFUL TO THE SCHOOL NURSE-TEACHER.

Who is providing this information? Parent ☐ Guardian ☐ Nurse Teacher, Registration Center ☐

_____
_____
_____
_____

FAMILY HEALTH HISTORY

(Please check off any of the following diseases or conditions if it applies)

Allergies _____	Mother ☐	Father ☐	Other: _____
Anemia _____	Mother ☐	Father ☐	Other: _____
Cancer _____	Mother ☐	Father ☐	Other: _____
Convulsive Disorder _____	Mother ☐	Father ☐	Other: _____
Diabetes _____	Mother ☐	Father ☐	Other: _____
Heart Disease _____	Mother ☐	Father ☐	Other: _____
High Blood Pressure _____	Mother ☐	Father ☐	Other: _____
Kidney Disease _____	Mother ☐	Father ☐	Other: _____

Where school did your child last attend? _____

I UNDERSTAND THIS INFORMATION MAY BE SHARED AND DISCUSSED WITH SCHOOL PERSONNEL IF NECESSARY. I GIVE PERMISSION TO APPROPRIATE SCHOOL PERSONNEL TO COMMUNICATE AND EXCHANGE INFORMATION WITH THE STUDENT'S PHYSICIAN, IF NECESSARY.

_____ _____
Signature Parent/Guardian ***Date***

Providence Public School District • Health Office
182 Thurbers Avenue, Providence, RI 02905 • Phone (401) 456.9317 • Fax (401) 456-0662

Blessed Sacrament School
240 Regent Avenue
Providence, RI 02908

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 5.4.

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 DTP/DTaP	Check ☐ if DT	Check ☐ if DT	Check ☐ if DT	Check ☐ if DT	Check ☐ if DT
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	Check ☐ if Td	Check ☐ if Td	Check ☐ if Td		
Rotavirus					
Hepatitis A					
Meningococcal					
HPV					

Immunization Exemption ☐ Medical ☐ Religious

☐ Hep B ☐ DTaP ☐ PCV ☐ Polio ☐ Hib ☐ MMR ☐ Varicella ☐ Td/Tdap ☐ Rotavirus ☐ Hep A ☐ Menino ☐ HPV

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)
Student is in compliance with lead screening requirements
Yes ☐ No ☐

SCOLIOSIS SCREENING
Yes ☐ No ☐

VISION SCREENING (Children entering Kindergarten)
☐ Passed screening
☐ Screened and referred for comprehensive exam
☐ Referred for comprehensive exam, but not screened
Screening Date: Comprehensive Exam Date:

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

HEALTH CARE PROVIDER SIGNATURE: _____ DATE _____

PRINT NAME: _____

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