PROMOTION OF HEALTH

Student Name: Last	First	Middle	Date of Birth	Sex M ☐ F ☐

Address:	School:	Gr.:	HR:	Home Phone

Date of PE ___/___/___	Height	Weight	Blood Pressure	SCOLIOSIS SCREEN ☐Pass ☐ Fail

HEALTH ASSESSMENT

This individual is in good health, is free of infectious disease and may participate in all school and athletic activities.

YES_____ **NO**_____

COMMENTS:_____

HEALTH HISTORY

ASTHMA: No ☐ Yes ☐ DIABETES: No ☐ Yes ☐ ALLERGIES: No ☐ Yes ☐ (Please explain)_____

Other significant health problems: _____

Additional Comments: _____

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.*

IMMUNIZATIONS					
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	___/___/___ OPV ☐ IPV or ☐	___/___/___ OPV ☐ IPV or ☐	___/___/___ OPV ☐ IPV or ☐	___/___/___ OPV ☐ IPV or ☐	
Haemophilus Influenzae Type B (HIB)	___/___/___	___/___/___	___/___/___	___/___/___	
Measles-Mumps-Rubella (MMR)	___/___/___	___/___/___			
Varicella	___/___/___	___/___/___	Student has history ☐ varicella disease		
Tetanus-Diphtheria (Td) (Gr.7 / 12 yrs.)	___/___/___	___/___/___			
Meningococcal	___/___/___	___/___/___			

LEAD SCREENING (Required for children <6 years of age only) Student is in compliance with lead screen requirements: Yes ☐ No ☐	VISION SCREENING (Required for children entering K) Pass ☐ Failed and referred for comprehensive exam ☐

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

Health Care Provider Signature:_____ **DATE:**_____

Print Name:_____