

CRANSTON PUBLIC SCHOOLS
PROMOTION OF HEALTH

Student Name: Last	First	Middle	Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>
Address:	School:	Gr.:	HR:	Home Phone
Date of PE / /	Height	Weight	Blood Pressure	SCOLIOSIS SCREEN Pass <input type="checkbox"/> Fail <input type="checkbox"/>

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/DTPaP)	/ / Check <input type="checkbox"/> if DT	/ / Check <input type="checkbox"/> if DT	/ / Check <input type="checkbox"/> if DT	/ / Check <input type="checkbox"/> if DT	/ / Check <input type="checkbox"/> if DT
Pneumococcal Conjugate (PCV)	/ /	/ /	/ /	/ /	
Polio	/ / IPV or OPV <input type="checkbox"/>	/ / IPV or OPV <input type="checkbox"/>	/ / IPV or OPV <input type="checkbox"/>	/ / IPV or OPV <input type="checkbox"/>	
Haemophilus Influenzae Type B (HIB)	/ /	/ /	/ /	/ /	
Measles-Mumps-Rubella (MMR)	/ /	/ /			
Varicella	/ /	/ /	Student has history varicella disease <input type="checkbox"/>		
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

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Health Care Provider Signature: _____ DATE: _____

Print Name: _____