CRANSTON PUBLIC SCHOOLS
PROMOTION OF HEALTH

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

Address:	School:	Gr.:	HR:	Home Phone

Date of PE _____/______/______	Height	Weight	Blood Pressure	SCOLIOSIS SCREEN ف Pass ف 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 ف Yes ف DIABETES: No ف Yes ف ALLERGIES: No ف Yes ف (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 ف if DT	_____/______/______ Check ف if DT	_____/______/______ Check ف if DT	____/______/______ Check ف if DT	_____/______/______ Check ف if DT
Pneumococcal Conjugate (PCV)	_____/______/______	_____/______/______	_____/______/______	_____/______/______	
Polio	_____/______/______ OPV ف IPV or ف	_____/______/______ OPV ف IPV or ف	_____/______/______ OPV ف IPV or ف	_____/______/______ OPV ف IPV or ف	
Haemophilus Influenzae Type B (HIB)	_____/______/______	_____/______/______	_____/______/______	_____/______/______	
Measles-Mumps-Rubella (MMR)	_____/______/______	_____/______/______			
Varicella	_____/______/______	_____/______/______	Student has history ف 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 ف No ف	VISION SCREENING (Required for children entering K) Pass ف Failed and referred for comprehensive exam ف

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

Health Care Provider Signature:________________________________**DATE:**__________________

Print Name:________________________________

STUDENT
HEALTH RECORD
CONFIDENTIAL

SCHOOL NURSE