JOHNSTON ATHLETIC DEPARTMENT PHYSICAL EXAMINATION FORM

JOHNSTON HIGH SCHOOL
345 CHERRY HILL RD
JOHNSTON, RI 02919

HEALTH CARE PROVIDER NAME _____
ADDRESS _____
JOHNSTON, RI 02919 PHONE: _____

This form may substitute for any district-issued form. All districts must accept this form. General health examinations shall be documented in a standard 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 DOB SEX GRADE

_____
ADDRESS APT.# CITY STATE ZIP CODE HOME PHONE

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 Website: http://www.health.ri.gov

PHYSICAL EXAMINATION (*Please note that all students must undergo an annual physical examination in order to participate in the Athletic Programs of the Johnston Public Schools*)

DATE OF PE _____/_____/_____ **HEIGHT**_____ **WEIGHT**_____ **BP**____/____

PLEASE NOTE: ANY HEALTH PROBLEM, CHRONIC CONDITION OR DISABILITY THAT MAY AFFECT BEHAVIOR HEALTH AT SCHOOL.

ASTHMA: NO_____ YES_____ DIABETES: NO_____ YES_____ OTHER_____
SIGNIFICANT SYSTEMS FINDINGS:_____
ALLERGIES: NO___ YES___ (PLEASE EXPLAIN) _____
TREATMENT PLAN:_____

MEDICATIONS (Required at School): NO___ YES____ (PLEASE LIST)_____

OTHER MEDICATION(S) THAT MAY AFFECT BEHAVIOR OR HEALTH AT SCHOOL:
_____

RESTRICTIONS: PARTICIPATE IN Physical Education: **Fully**___ **With Limitations**_____
CAN PARTICIPATE IN Sports: **Fully**_____ **With Limitations**_____

HEALTH CARE PROVIDER SIGNATURE: _____ **DATE:** _____

COMMENTS: _____

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