Jewish Alliance OF GREATER RHODE ISLAND

Dwares JCC Rhode Island

HEALTH HISTORY FORM

Healthcare Provider Name & Address:_____

_____

[Address] [City] [State] [Zip]

PHYSICAN'S SIGNATURE AND WELL-CHILD VISIT MUST BE DATED WITHIN THE PAST YEAR!

Child's Name: Last _____ **First**_____ **Middle**_____

D.O.B._____ **Sex**_____

Address (street/apt#/City/State/Zip)_____ **Phone#**_____

PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript.)

IMMUNIZATIONS	**Please enter dates in MM/DD/YYYY format.**				
Hepatitis B					
Diptheria-Tetanus-Pertussis DIP/DTaP	Check ( ) if DT	Check ( ) if DT	Check ( ) if DT	Check ( ) if DT	Check ( ) if DT
Pneumococcal Conjugate PCV					
Polio					
Haemophilius Influenza Type B Hib					
Measles-Mumps-Rubella MMR					
Varicella			( ) Students has a history of varicella disease		
Tetanus-Diptheriea-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 ( )Mening ( )HPR

PHYSICAL EXAMINATION

Date of PE_____/_____/_____ **Height**_____ **Weight**_____ **BP**_____

Please note any health problem, chronic health condition or disability that may affect behavior 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 ≤ 5 years of age only)
Student is in compliance with lead screening requirements:
Yes ( ) No ( )

SCOLIOSIS SCREEING
Yes ( ) No ( )

VISTION 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:_____

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