RHODE ISLAND PUBLIC SCHOOLS
PHYSICAL EXAMINATION—IMMUNIZATION RECORD

Dear Parent,

Every student entering a public or non-public school in this State for the first time shall have a complete medical history and physical examination done. Physical examinations shall be repeated in grade four and grade seven.

Child's Name_____ Birthdate _____ Sex _____

Address _____ School _____ Grade ____

Doctor's
Name_____ Address _____

THIS SECTION TO BE COMPLETED BY HEALTH PROFESSIONAL

Height _____ Weight _____ B.P. _____ Femoral Pulse _____

Eyes ____ Glasses/Contacts: Yes ____ No ____ Abdomen: Hernia Yes ____ No ____

Ears _____ Orthopedic _____

Nose _____ Scoliosis: Negative _____ Positive _____

Tonsils _____ Nervous System _____

Glands: Cervical _____ Thyroid _____ Skin _____

Heart: Murmurs: Functional_____ Organic_____ None _____

Lungs _____ Speech _____

Serious Illness, Injuries, or Operation: _____

Ability to participate in Physical Education: _____

Allergies: _____

Regular, continuing long term medication: Yes ____ No ____

Name of medication, dosage, frequency _____

IMMUNIZATIONS REQUIRED BY RHODE ISLAND STATE LAW

	Month/Day/Year	Month/Day/Year	Month/Day/Year	Month/Day/Year	Month/Day/Year
DTP/DTaP					
Td					
Polio					XXXXXXXXX
MMR			XXXXXXXXX	XXXXXXXXX	XXXXXXXXX
HIB				XXXXXXXXX	XXXXXXXXX
HepBV				XXXXXXXXX	XXXXXXXXX
Varicella		XXXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXXXXX

Documented Chicken Pox: Date _____

Lead Screening: Date _____ Normal _____ Elevated _____

TB: Date _____ Type _____ mm. Induration _____

Other _____

_____ _____

Signature of Examiner Date

SUMMARY OF RHODE ISLAND IMMUNIZATION REQUIREMENTS AND EXEMPTIONS

2009–2010 ENTRY REQUIREMENTS					
VACCINE	**School GRADE Level**	**TOTAL # OF DOSES**	**MINIMUM AGE FOR FIRST DOSE**	**MINIMUM INTERVALS (BETWEEN DOSES)**	
DTP/DtaP (Diphtheria, Tetanus, & Pertussis)	**All**	**5 or 4** (4 doses only if 4th dose after age 4)	**6 Weeks**	***Dose #1, 2, 3*** ***Dose #4***	**4 weeks between each dose** **6 months after #3**
Td (Tetanus & Diphtheria)	**All**	**3**	**7 Years**	***Dose #1, 2*** ***Dose #3***	**4 weeks between each dose** **6 months after #2**
POLIO – OPV (Oral Poliovirus)	**All**	**4 or 3** (3 doses only if 3rd dose after age 4)	**6 Weeks**	***Dose #1, 2, 3***	**4 weeks between each dose**
POLIO – OPV (Inactivated Poliovirus)	**All**	**4 or 3** (3 doses only if 3rd dose after age 4)	**6 Weeks**	***Dose #1, 2*** ***Dose #3***	**4 weeks between each dose** **6 months after #2**
MMR (Measles, Mumps, & Rubella)	**All**	**2**	**12 Months** (On or after 1st birthday)	***Dose #1, 2***	**1 month**
Hepatitis B	**K-4, 7-10**	**3**		***Dose #1, 2*** ***Dose #3***	**1 month** **6 months after #2**
Varicella Vaccine (Chicken Pox)	**K-4, 7-10**	(Vaccine or note from Doctor with date of infection)			

EXEMPTIONS	
TYPE	**DEFINITION**
MEDICAL	A licensed physician signs a medical exemption stating the student is exempt from a specific vaccine because of medical reasons in accordance with: • ACIP guidelines, AAP guidelines, or vaccine package insert instructions, or • Laboratory confirmation of disease.
RELIGIOUS	A parent or guardian completes and signs the ***Immunization Exemption Form*** on the grounds of religious beliefs.
TEMPORARY	The administrative head of the school or his/her designee signs a ***Temporary Exemption Form*** indicating that there is evidence of a scheduled appointment with a health care provider for the required immunization(s). This temporary exemption will expire on the date of the scheduled appointment.

District:
Grade:
School:

RHODE ISLAND DEPARTMENT OF HEALTH
IMMUNIZATION EXEMPTION FORM

Student Name:

Address:

Phone:

I. Medical Exemption

The above named child is exempt from receiving the following vaccine(s) due to the medical contraindication listed below. This child's contraindication(s) is in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines, American Academy of Pediatrics (AAP) guidelines, or vaccine package insert instructions.

☐ DTaP/DTP ☐ DT ☐ Td ☐ Hib ☐ Hepatitis B ☐ IPV ☐ OPV ☐ MMR ☐ Varicella ☐ Other

Permanent Contraindications: (Check where applicable)
☐ History of anaphylactic or anaphylactic-like reaction to a prior dose of the vaccine or a vaccine component.
☐ Previous encephalopathy within 7 days after DTaP/DTP
☐ Undiagnosed progressive neurologic problem after DTaP/DTP
☐ Previous history of T≥105 F (40.5 C) within 48 hours after DTaP/DTP.
☐ Previous continuous crying lasting 3 or more hours within 48 hours after DTaP/DTP:
☐ Previous convulsion within 3 days after immunization after DTaP/DTP.
☐ Previous pale or limp episode, or collapse within 48 hours after DTaP/DTP.
☐ Other _____

Temporary Contraindications: (Check where applicable)
☐ Moderate or severe acute illness with or with out fever.
☐ Student is pregnant.
☐ Student is immunocomprimised.
☐ Blood products or immunoglobulin administered during the past 11 months.
☐ Other _____

Expiration date: ___/___/___

Date _____ Physician Signature _____

II. Religious Exemption

I object to having my child receive the required vaccines because of my religious beliefs. I understand that in the event of any vaccine-preventable disease outbreak which may occur in the school, my child would be excluded for the duration of the outbreak, or until the required vaccinations are obtained.

Date _____ Parent/Guardian Signature _____

Date _____ Administrative Head of School or Designee Signature _____

White. School
Yellow. Parent
Pink. RI Department of Health