School Name & Address:

Grade: _____

STATE OF RHODE ISLAND
SCHOOL PHYSICAL FORM

Health Care Provider Name and Address:

Phone:

This form may substitute for any district-issued form. All districts must accept this form. General health examinations shall be documented in a standardized 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	Date of Birth	Sex

Address: Street	Apt #	City	State	Zip Code	Home Phone

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

IMMUNIZATIONS	Please enter dates in MM/DD/YYYY format				
Hepatitis B					
Diphtheria-Tetanus-Pertussis DTaP < 7 years					
Pneumococcal Conjugate PCV					
Polio					
Haemophilus Influenzae Type B Hib					
Measles-Mumps-Rubella MMR					
Varicella			☐ Student has history of varicella disease		
Tetanus-Diphtheria-Pertussis Tdap/Td ≥ 7 years					
Rotavirus					
Hepatitis A					
Meningococcal					
HPV					
Influenza					

Medical Exemption:

☐ Hep B ☐ DTaP ☐ PCV ☐ Polio ☐ Hib ☐ MMR ☐ Varicella ☐ Td/Tdap ☐ Rotavirus ☐ Hep A ☐ Mening ☐ HPV ☐ Influenza

PHYSICAL EXAMINATION

Date of PE ____/____/____ Height _____ Weight _____ BP _____

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

1. ASTHMA: No☐ Yes☐ If yes, complete an *Asthma Action Plan* (www.health.ri.gov/publications/actionplans/2012Asthma.pdf)
2. ALLERGIES: No☐ Yes☐ (Please explain) _____ EPINEPHRINE AUTO-INJECTOR REQUIRED: No☐ Yes☐

If student has a severe allergy (food, insect, other) complete a *Food Allergy& Anaphylaxis Emergency Care Plan* (www.foodallergy.org/document.doc?id=234)

3. DIABETES: No☐ Yes☐ If yes, complete a *Physicians Order Form For Students With Diabetes* (www.health.ri.gov/forms/school/PhysicianOrdersForStudentsWithDiabetes.pdf)
4. OTHER: _____

Treatment Plan: _____

RESTRICTIONS: Can participate in physical education/sports: Fully☐ With limitation☐ _____

MEDICATION (REQUIRED AT SCHOOL): No☐ Yes☐ (Please list) _____

Other medication(s) that may affect behavior or health at school: _____

LEAD SCREENING (Required for children < 6 years old)	SCOLIOSIS SCREENING	VISION SCREENING (Children entering Kindergarten)
Student is in compliance with lead screening requirements: Yes☐ No☐	Yes☐ No☐	☐ Passed Screening ☐ Screened & referred for comprehensive exam ☐ Referred for comprehensive exam, but not screened
TUBERCULOSIS (If required by school district) Date of TB test:		Screening / Referral Date: Comprehensive Exam Date:

HEALTH CARE PROVIDER SIGNATURE: _____ DATE: _____

PRINT NAME: _____

6-2016

CHILD CARE CENTER

PARENT AUTHORIZATION FOR EMERGENCY TREATMENT

In consideration of admittance, I hereby authorize

_____

Name of Child Care Center

to arrange for medical examination and/or treatment of my child,

_____

Name of Child

should an emergency arise at the child care center or on a field trip. It is understood that a conscientious effort will be made by the child care center to contact me at the emergency numbers I have provided below before any medical action is taken.

I would prefer to have my child taken to the following hospital if the need arises: _____. I understand that

Hospital

choice of hospital may be limited by service of local rescue squad.

_____	_____	_____
Signature-Mother/Guardian	**Home Phone**	**Business Phone**
_____	_____	_____
Signature-Father/Guardian	**Home Phone**	**Business Phone**

Health Insurance Plan _____

Policy Number _____

****

Relatives or other persons to be contacted in an emergency:

Name _____ **Name** _____

Address _____ **Address** _____

_____ _____

Phone _____ **Phone** _____

Relationship to Child _____ **Relationship to Child** _____

_____

Date

PARENTS AUTHORIZATION RELEASE FORM

In accordance with the Child Day Care Center Regulations we must have on file the names and addresses of all persons who are authorized to take your child(ren) from the center, including any pertinent custody information. If someone arrives to take your child, and their name is not on file, we cannot allow your child to leave with them.

Please list below any person's name, address and telephone number, who might arrive to take your child. The individual must show proper identification (photo ID).

Name:	**Address:**	**Phone #:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent's signature_____ **Date**_____

Parent's signature_____ **Date**_____

Springboard Registration Form

Today's Date _____ Start Date _____

Child's Name _____ Sex _____ Age _____ Date of Birth _____

Home Address (Street) _____

City _____ State _____ Zip _____ Home Phone Number _____

Primary Language of child: _____ Parent: _____

Parent/Guardian Information

Parent/Guardian Name _____ Home Phone Number _____

Street Address (if different from child's) _____

City _____ State _____ Zip _____

Relationship to child _____

Business Name _____ Business Phone Number _____

Address Street _____

City _____ State _____ Zip _____

Email Address _____ Cell Phone Number _____

Parent/Guardian Name _____ Home Phone Number _____

Street Address (if different from child's) _____

City _____ State _____ Zip _____

Relationship to child _____

Business Name _____ Business Phone Number _____

Address Street _____

City _____ State _____ Zip _____

Email Address _____ Cell Phone Number _____

Child's Living Arrangements: (check one) ( )Both Parents ( )Mother ( )Father ( )Other

Child's Legal Guardian(s): (check one) ( )Both Parents ( )Mother ( )Father ( )Other

Is there a custody agreement or restriction to parental contact? ( )Yes ( ) No

Springboard Registration Form

If YES, please submit a copy of the applicable section of the most recent version of your custody agreement with this registration form.

Emergency Contacts

In case of emergency and parents/guardians are not able to be reached, please list names that can act on your behalf for the care of your children.

Name _____ Relationship to child_____

Home Phone Number_____ Cell Phone Number_____

Address Street _____

City _____State _____Zip_____

Name _____ Relationship to child_____

Home Phone Number_____ Cell Phone Number_____

Address Street _____

City _____State _____Zip_____

Health Information

Child's Physician _____ Phone_____

Address Street _____

City _____State _____Zip_____

Health Insurance Carrier: _____Policy Number_____

Child's Dentist_____Phone_____

Address Street _____

City _____State _____Zip_____

Dental Insurance Carrier:_____Policy Number:_____

Does your child have any allergies, special diet, chronic health conditions and/or special limitations or concerns? (check one) ( ) Yes ( ) No

If yes, please list_____

And, you will be required to have an Individual Health Care Policy for your child prior to enrollment.

Child's Identifying Marks_____Race _____Height _____ Weight _____Hair Color _____

Eye Color _____Additional Information:_____

Springboard Registration Form

Authorizations

Enrollment Information: I have read and understand the enrollment information on admission and tuition. Initial _____

Updated Child's Records: I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g., telephone numbers, work location, emergency contacts, child's physician, child's health status and immunization records, etc. Initial _____

Hospital Transportation: In case of medical emergency I give permission for Springboard to release my child and to be transported to a hospital. My preferred hospital is:
(Name of Hospital) _____

(Hospital Address) _____

(Hospital Phone Number) (_____)_____ or to the nearest hospital by ambulance subject to the EMT's authority once child has been released to their care. Initial _____

First Aid/CPR: I give permission for Springboard staff to administer First Aid & CPR to my child, if necessary. Initial _____

In the event of an emergency: I give Springboard permission to act on my behalf and provide needed medication and assistance. Initial _____

Video/Picture Permission Slip - External: I give permission and consent for Springboard to take pictures/video of my child during program hours and activities. I further give permission and consent that any such photographs/video may be published and used by Springboard Education in America and its agents, to illustrate and promote the Springboard experience on **Springboard's website, social media, or for the purpose of brochures and advertisements.** Initial ___

Video/Picture Permission Slip – Internal: I give permission for Springboard to take pictures/video of my child during program hours and activities to be used for **internal purposes posted at Springboard site, Class Dojo and/or Shutterfly.** Initial ___

Release of Records: I authorize Springboard to access and review all health and educational records on file with my child's school, for the purposes of providing a safe, healthy environment that supports my child's academic growth and achievement. This data may include, but is not limited to, an IEP, disability evaluations and test data. Springboard adheres to the highest levels of confidentiality when accessing information contained in these records. Initial _____

Medications: I understand that in order for my child to be given medications (prescriptions and/or over the counter medications), I must provide written authorization by the physician and parent. Medication must be provided in the original bottle with an original label. Initial _____

Sunscreen: I give permission for Springboard to apply sunscreen to my child if assistance is needed. I will supply the sunscreen in its original bottle to you clearly labeled with my child's name. Initial _____

TV/Video: I give permission for my child to use or view TV and or video games during their time at Springboard. I understand that the site coordinator monitors all TV exposure and videos. Initial _____

Parent Agreement: The child named on this form is "awesome," but I understand that children who behave in a "not-so-awesome" way can get sent home from their program without a refund. Initial _____

Springboard Registration Form

In signing below I am acknowledging that my child's physical and immunizations are up to date and located at (name of school) _____

Anticipated enrollment days and times _____

I have read and initialed the above Authorizations and have completed this form and confirmed its accuracy.

Parent Signature _____ Date _____

Print Parent Name _____

All students must have a completed, signed enrollment form on file at the program in order to attend the Springboard Program. Please return your completed form to the Springboard Program at your child's school.