**COMMONWEALTH OF VIRGINIA**
**SCHOOL ENTRANCE HEALTH FORM**
**Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization**

## Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no longer than one year before your child's entry into school.

Name of School: _____ Current Grade: _____

Student's Name: _____
Last First Middle

Student's Date of Birth: _____/_____/_____ Sex: _____ State or Country of Birth: _____ Main Language Spoken: _____

Student's Address: _____ City: _____ State: _____ Zip: _____

Name of Parent or Legal Guardian 1: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Name of Parent or Legal Guardian 2: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Emergency Contact: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

| Condition | Yes | Comments | Condition | Yes | Comments |
|---|---|---|---|---|---|
| Allergies (food, insects, drugs, latex) | | | Diabetes | | |
| Allergies (seasonal) | | | Head injury, concussions | | |
| Asthma or breathing problems | | | Hearing problems or deafness | | |
| Attention-Deficit/Hyperactivity Disorder | | | Heart problems | | |
| Behavioral problems | | | Lead poisoning | | |
| Developmental problems | | | Muscle problems | | |
| Bladder problem | | | Seizures | | |
| Bleeding problem | | | Sickle Cell Disease (not trait) | | |
| Bowel problem | | | Speech problems | | |
| Cerebral Palsy | | | Spinal injury | | |
| Cystic fibrosis | | | Surgery | | |
| Dental problems | | | Vision problems | | |

Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.):_____

_____

List all prescription, over-the-counter, and herbal medications your child takes regularly:

_____

Check here if you want to discuss confidential information with the school nurse or other school authority. ☐ Yes ☐ No

Please provide the following information:

| | Name | Phone | Date of Last Appointment |
|---|---|---|---|
| Pediatrician/primary care provider | | | |
| Specialist | | | |
| Dentist | | | |
| Case Worker (if applicable) | | | |

Child's Health Insurance: ____ None ____ FAMIS Plus (Medicaid) _____ FAMIS _____ Private/Commercial/Employer sponsored

**I, _____ (do___) (do not___) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form.** *This authorization will be in place until or unless you withdraw it.* ***You may withdraw your authorization at any time by contacting your child's school****. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.*

**Signature** of Parent or Legal Guardian: _____Date: _____/_____/ _____

**Signature** of person completing this form: _____Date:_____/_____/_____

**Signature** of Interpreter: _____Date: _____/_____/_____

**COMMONWEALTH OF VIRGINIA**
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**Part II - Certification of Immunization**

***Section I***

**To be completed by a physician or his designee, registered nurse, or health department official.**
**See Section II for conditional enrollment and exemptions.**

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.
Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Student's Name:_____ Date of Birth: |____|____|____|
*Last* *First* *Middle* *Mo. Day Yr.*

| IMMUNIZATION | RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN | | | | |
|---|---|---|---|---|---|
| *Diphtheria, Tetanus, Pertussis (DTP, DTaP) | **1** | **2** | **3** | **4** | **5** |
| *Diphtheria, Tetanus (DT) or Td (given after 7 years of age) | **1** | **2** | **3** | **4** | **5** |
| *Tdap booster (6th grade entry) | **1** | | | | |
| *Poliomyelitis (IPV, OPV) | **1** | **2** | **3** | **4** | |
| *Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age | **1** | **2** | **3** | **4** | |
| *Pneumococcal (PCV conjugate) *only for children <60 months of age | **1** | **2** | **3** | **4** | |
| Measles, Mumps, Rubella (MMR vaccine) | **1** | **2** | | | |
| *Measles (Rubeola) | **1** | **2** | Serological Confirmation of Measles Immunity: | | |
| *Rubella | **1** | | Serological Confirmation of Rubella Immunity: | | |
| *Mumps | **1** | **2** | | | |
| *Hepatitis B Vaccine (HBV) ❑ Merck adult formulation used | **1** | **2** | **3** | | |
| *Varicella Vaccine | **1** | **2** | Date of Varicella Disease OR Serological Confirmation of Varicella Immunity: | | |
| Hepatitis A Vaccine | **1** | **2** | | | |
| Meningococcal Vaccine | **1** | | | | |
| Human Papillomavirus Vaccine | **1** | **2** | **3** | | |
| Other | **1** | **2** | **3** | **4** | **5** |
| Other | **1** | **2** | **3** | **4** | **5** |

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Reference Section III).

**Signature of Medical Provider or Health Department Official:**_____ **Date (*Mo., Day, Yr.*):**___/___/____

Student's Name:_____Date of Birth: |____ |_ ___|___ _|

## *Section II*
## *Conditional Enrollment and Exemptions*

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date.

**MEDICAL EXEMPTION:** As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

_____
_____
_____.

DTP/DTaP/Tdap:[___]; DT/Td:[___]; OPV/IPV:[___]; Hib:[___]; Pneum:[___]; Measles:[___]; Rubella:[___]; Mumps:[____]; HBV:[___]; Varicella:[___]

This contraindication is permanent: [___], or temporary [___] and expected to preclude immunizations until: Date (*Mo., Day, Yr.*): |___|___|___|.

**Signature of Medical Provider or Health Department Official:_____ Date (*Mo., Day, Yr.*):|___|___|___|**

**RELIGIOUS EXEMPTION:** The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

**CONDITIONAL ENROLLMENT:** As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on _____.

**Signature of Medical Provider or Health Department Official:_____ Date (*Mo., Day, Yr.*):|___|___|___|**

## *Section III*
## *Requirements*

# For Minimum Immunization Requirements for Entry into School and Day Care, consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

**Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations** (Ref. *Code of Virginia* § 32.1-46(a)).
**(Requirements are subject to change.)**

## Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

**A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III**. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth.

Student's Name: _____ Date of Birth: _____/_____/_____ Sex: ☐ M ☐ F

**Health Assessment**

**Date of Assessment:** _____/_____/_____

Weight: _____lbs. Height: _____ ft. _____ in.

Body Mass Index (BMI): _____ BP_____

❑ Age / gender appropriate history completed

❑ Anticipatory guidance provided

**Physical Examination**

1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment

| | 1 | 2 | 3 | | 1 | 2 | 3 | | 1 | 2 | 3 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| HEENT | □ | □ | □ | Neurological | □ | □ | □ | Skin | □ | □ | □ |
| Lungs | □ | □ | □ | Abdomen | □ | □ | □ | Genital | □ | □ | □ |
| Heart | □ | □ | □ | Extremities | □ | □ | □ | Urinary | □ | □ | □ |

**TB Screening: □ No risk for TB infection identified □ No symptoms compatible with active TB disease**
**□ Risk for TB infection or symptoms identified**
**Test for TB Infection: TST IGRA Date:_____ TST Reading _____mm TST/IGRA Result: □ Positive □ Negative**
**CXR required if positive test for TB infection or TB symptoms. CXR Date: _____ □ Normal □ Abnormal**

**EPSDT Screens Required for Head Start – include specific results and date:**
Blood Lead:_____ Hct/Hgb _____

**Developmental Screen**

| *Assessed for:* | *Assessment Method:* | *Within normal* | *Concern identified:* | *Referred for Evaluation* |
|---|---|---|---|---|
| Emotional/Social | | | | |
| Problem Solving | | | | |
| Language/Communication | | | | |
| Fine Motor Skills | | | | |
| Gross Motor Skills | | | | |

**Hearing Screen**

❑ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.

| | 1000 | 2000 | 4000 |
|---|---|---|---|
| R | | | |
| L | | | |

❑ Screened by OAE (Otoacoustic Emissions): □ Pass □ Refer

□ Referred to Audiologist/ENT □ **Unable to test – needs rescreen**

□ Permanent Hearing Loss Previously identified: ___Left ___Right

□ Hearing aid or other assistive device

**Vision Screen**

❑ With Corrective Lenses (check if yes)

| Stereopsis | ❑ Pass | ❑ Fail | | ❑ Not tested |
|---|---|---|---|---|
| Distance | Both | R | L | Test used: |
| | 20/ | 20/ | 20/ | |

❑ Pass ❑ Referred to eye doctor ❑ **Unable to test – needs rescreen**

**Dental Screen**

❑ Problem Identified: Referred for treatment

❑ No Problem: Referred for prevention

❑ No Referral: Already receiving dental care

**Recommendations to (Pre) School , Child Care, or Early Intervention Personnel**

**Summary of Findings** (check one):
□ **Well child; no conditions identified of concern to school program activities**
□ **Conditions identified that are important to schooling or physical activity** (complete sections below and/or explain here): _____
_____

___ **Allergy** □ food: _____ □ insect: _____ □ medicine: _____ □ other: _____
Type of allergic reaction: □ anaphylaxis □ local reaction Response required: □ none □ epinephrine auto-injector □ other: _____

___**Individualized Health Care Plan needed** (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)

___ **Restricted Activity** Specify: _____

___ **Developmental Evaluation** □ Has IEP □ Further evaluation needed for: _____

___ **Medication**. Child takes medicine for specific health condition(s). □ Medication must be given and/or available at school.

___ **Special Diet** Specify: _____

___ **Special Needs** Specify: _____

**Other Comments:** _____

**Health Care Professional's Certification** (Write legibly or stamp) **□ By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).**

**Name**: _____ **Signature:** _____ Date: ____/_____/_____

**Practice/Clinic Name**: _____ **Address**: _____

**Phone**: _____-_____-_____ **Fax**: _____-_____-_____ **Email:** _____