

# 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 earlier 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 Code \_\_\_\_\_

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: \_\_\_\_-\_\_\_\_-\_\_\_\_

Hospital Preference: \_\_\_\_\_

Child's Health Insurance: ☐ None ☐ FAMIS Plus (Medicaid) ☐ FAMIS ☐ Private/Commercial/Employer Sponsored \_\_\_\_\_

| Box 1. PreExisting Conditions                                                                                                                                                                                                                                                                                                              |     |          |                                 |     |          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----------|---------------------------------|-----|----------|
| Condition                                                                                                                                                                                                                                                                                                                                  | Yes | Comments | Condition                       | Yes | Comments |
| Allergies (food, insects, drugs, latex)                                                                                                                                                                                                                                                                                                    |     |          | Diabetes: Type 1                |     |          |
| Please list Life Threatening Allergies:                                                                                                                                                                                                                                                                                                    |     |          | Diabetes: Type 2                |     |          |
|                                                                                                                                                                                                                                                                                                                                            |     |          | Insulin pump                    |     |          |
| Allergies (seasonal)                                                                                                                                                                                                                                                                                                                       |     |          | Head injury, concussion         |     |          |
| Asthma or breathing conditions                                                                                                                                                                                                                                                                                                             |     |          | Hearing conditions or deafness  |     |          |
| Attention Deficit/Hyperactivity Disorder                                                                                                                                                                                                                                                                                                   |     |          | Heart conditions                |     |          |
| Behavioral/Psych/Social conditions                                                                                                                                                                                                                                                                                                         |     |          | Lead poisoning                  |     |          |
| Developmental conditions                                                                                                                                                                                                                                                                                                                   |     |          | Muscle conditions               |     |          |
| Bladder conditions                                                                                                                                                                                                                                                                                                                         |     |          | Seizures                        |     |          |
| Bleeding conditions                                                                                                                                                                                                                                                                                                                        |     |          | Sickle Cell Disease (not trait) |     |          |
| Bowel conditions                                                                                                                                                                                                                                                                                                                           |     |          | Speech conditions               |     |          |
| Cerebral Palsy                                                                                                                                                                                                                                                                                                                             |     |          | Spinal injury                   |     |          |
| Cystic fibrosis                                                                                                                                                                                                                                                                                                                            |     |          | Surgery                         |     |          |
| Dental Health conditions                                                                                                                                                                                                                                                                                                                   |     |          | Vision conditions               |     |          |
| Describe any other important health-related information about your child ( <input type="checkbox"/> Feeding tube, <input type="checkbox"/> Trach, <input type="checkbox"/> Oxygen support, <input type="checkbox"/> Hearing aids, <input type="checkbox"/> Dental appliance, <input type="checkbox"/> Wheelchair, Hospitalizations, etc.): |     |          |                                 |     |          |

| Box 2. Medications                                                                                                   |        |                                 |       |
|----------------------------------------------------------------------------------------------------------------------|--------|---------------------------------|-------|
| List all prescription, emergency, over-the-counter, and herbal medications your child takes regularly (Home/School): |        |                                 |       |
| Medication Name                                                                                                      | Dosage | Time Administered (Home/School) | Notes |
| 1.                                                                                                                   |        |                                 |       |
| 2.                                                                                                                   |        |                                 |       |
| 3.                                                                                                                   |        |                                 |       |
| 4.                                                                                                                   |        |                                 |       |
| Additional Medications (Name, Dose, Time Administered, Notes)                                                        |        |                                 |       |

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

| Type                               | Name | Phone | Date of Last Appointment |
|------------------------------------|------|-------|--------------------------|
| Pediatrician/Primary Care Provider |      |       |                          |
| Specialist                         |      |       |                          |
| Dentist                            |      |       |                          |
| Case Worker (if applicable)        |      |       |                          |

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 Interpreter: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

# COMMONWEALTH OF VIRGINIA SCHOOL ENTRANCE HEALTH FORM

## Part II – Certification of Immunization

A copy of child's  
immunization records  
is attached



### Section I

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 official of health department indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording the dates on this page, as long as the completed immunization record is attached to the School Entrance Health Form: Part II Certification of Immunization (MCH213G).

As per 12VAC5-110-70, the Certification of Immunization form must be signed and dated by the Medical Provider (physician or designee, registered nurse, or official of the health department) in the appropriate box below. Contact local health department for assistance with foreign vaccine records.

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_

Race (optional): \_\_\_\_\_ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

| IMMUNIZATION                                                                              | RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN |   |                                                                              |   |   |
|-------------------------------------------------------------------------------------------|-----------------------------------------------------------------|---|------------------------------------------------------------------------------|---|---|
| Diphtheria, Tetanus, Pertussis Vaccine (DTP, DTaP)                                        | 1                                                               | 2 | 3                                                                            | 4 | 5 |
| Diphtheria, Tetanus (DT) or Tdap or Td Vaccine (given after 7 years of age)               | 1                                                               | 2 | 3                                                                            | 4 | 5 |
| Tdap Vaccine booster                                                                      | 1                                                               |   |                                                                              |   |   |
| Poliomyelitis Vaccine (IPV, OPV)                                                          | 1                                                               | 2 | 3                                                                            | 4 | 5 |
| Haemophilus influenzae Type b Vaccine (Hib conjugate) only for children <60 months of age | 1                                                               | 2 | 3                                                                            | 4 |   |
| Rotavirus Vaccine (RV) only for children < 8 months of age                                | 1                                                               | 2 | 3                                                                            |   |   |
| Pneumococcal Vaccine (PCV conjugate) only for children <60 months of age                  | 1                                                               | 2 | 3                                                                            | 4 |   |
| Varicella Vaccine                                                                         | 1                                                               | 2 | Date of Varicella Disease OR Serological Confirmation of Varicella Immunity: |   |   |
| Measles, Mumps, Rubella Vaccine (MMR vaccine)                                             | 1                                                               | 2 |                                                                              |   |   |
| Measles Vaccine (Rubeola)                                                                 | 1                                                               | 2 | Serological Confirmation of Measles Immunity:                                |   |   |
| Rubella Vaccine                                                                           | 1                                                               | 2 | Serological Confirmation of Rubella Immunity:                                |   |   |
| Mumps Vaccine                                                                             | 1                                                               | 2 | Serological Confirmation of Mumps Immunity:                                  |   |   |
| Hepatitis B Vaccine (HBV)<br><input type="checkbox"/> Merck adult formulation used        | 1                                                               | 2 | 3                                                                            | 4 |   |
| Hepatitis A Vaccine                                                                       | 1                                                               | 2 |                                                                              |   |   |
| Meningococcal ACWY Vaccine                                                                | 1                                                               | 2 |                                                                              |   |   |
| Meningococcal B Vaccine                                                                   | 1                                                               | 2 | 3                                                                            |   |   |
| Human Papillomavirus Vaccine (HPV)                                                        | 1                                                               | 2 | 3                                                                            |   |   |
| Influenza (Yearly)                                                                        | 1                                                               | 2 | 3                                                                            | 4 | 5 |
| Other                                                                                     | 1                                                               | 2 | 3                                                                            | 4 | 5 |
| Other                                                                                     | 1                                                               | 2 | 3                                                                            | 4 | 5 |

### Certification of Immunization

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: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Section II Conditional Enrollment and Exemptions

A qualified licensed physician, nurse practitioner, or physician assistant must complete the medical exemption or conditional enrollment section as appropriate to include signature and date. This section must be attached to Part I Health Information (to be filled out and signed by parent).

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent or Legal Guardian Name: \_\_\_\_\_

Parent or Legal Guardian Name: \_\_\_\_\_

Phone Number: \_\_\_\_-\_\_\_\_-\_\_\_\_

**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    ☐ PCV    ☐ RV    ☐ Measles    ☐ Mumps  
☐ Rubella    ☐ VAR    ☐ Men ACWY    ☐ Men B    ☐ Hep A    ☐ HBV

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 (or 180 days for Hepatitis B). **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 <https://www.vdh.virginia.gov/immunization/requirements>**

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 and sign 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.vdh.virginia.gov/school-age-health-and-forms/school-health-forms-and-action-plans](http://www.vdh.virginia.gov/school-age-health-and-forms/school-health-forms-and-action-plans)

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: ☐ M ☐ F

|                                                                                                                                                                                                                  |                                                                     |                                                                                 |   |   |   |              |   |   |   |         |   |   |   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------------------|---|---|---|--------------|---|---|---|---------|---|---|---|
| <b>Health Assessment</b>                                                                                                                                                                                         | Date of Assessment: ____/____/____                                  | <b>Physical Examination</b>                                                     |   |   |   |              |   |   |   |         |   |   |   |
|                                                                                                                                                                                                                  | Weight: ____ lbs Height: ____ ft ____ in                            | 1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment |   |   |   |              |   |   |   |         |   |   |   |
|                                                                                                                                                                                                                  | Body Mass Index (BMI): _____ BP _____                               |                                                                                 | 1 | 2 | 3 |              | 1 | 2 | 3 |         | 1 | 2 | 3 |
|                                                                                                                                                                                                                  | <input type="checkbox"/> Age / gender appropriate history completed | HEENT                                                                           |   |   |   | Neurological |   |   |   | Skin    |   |   |   |
|                                                                                                                                                                                                                  | <input type="checkbox"/> Anticipatory guidance provided             | Lungs                                                                           |   |   |   | Abdomen      |   |   |   | Genital |   |   |   |
|                                                                                                                                                                                                                  |                                                                     | Heart                                                                           |   |   |   | Extremities  |   |   |   | Urinary |   |   |   |
| <b>Tuberculosis Screening</b>                                                                                                                                                                                    |                                                                     |                                                                                 |   |   |   |              |   |   |   |         |   |   |   |
| Check the box that applies:                                                                                                                                                                                      |                                                                     |                                                                                 |   |   |   |              |   |   |   |         |   |   |   |
| <input type="checkbox"/> No risk for TB infection identified <input type="checkbox"/> No symptoms compatible with active TB disease <input type="checkbox"/> Risk for TB infection or symptoms identified: _____ |                                                                     |                                                                                 |   |   |   |              |   |   |   |         |   |   |   |
| Test for TB Infection: TST IGRA Date: ____/____/____ TST Reading _____ mm TST/IGRA Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive                                                   |                                                                     |                                                                                 |   |   |   |              |   |   |   |         |   |   |   |
| CXR required if positive test for TB infection or TB symptoms. CXR Date: ____/____/____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal                                                        |                                                                     |                                                                                 |   |   |   |              |   |   |   |         |   |   |   |
| <b>EPSDT Screens Required for Head Start – include specific results and date:</b>                                                                                                                                |                                                                     |                                                                                 |   |   |   |              |   |   |   |         |   |   |   |
| Blood Lead: _____ Hct/Hgb: _____                                                                                                                                                                                 |                                                                     |                                                                                 |   |   |   |              |   |   |   |         |   |   |   |

|                             |                        |                    |               |                     |                         |
|-----------------------------|------------------------|--------------------|---------------|---------------------|-------------------------|
| <b>Developmental Screen</b> | Assessed for:          | Assessment Method: | Within Normal | Concern Identified: | Referred for Evaluation |
|                             | Emotional/Social       |                    |               |                     |                         |
|                             | Problem Solving        |                    |               |                     |                         |
|                             | Language/Communication |                    |               |                     |                         |
|                             | Fine Motor Skills      |                    |               |                     |                         |
|                             | Gross Motor Skills     |                    |               |                     |                         |

|                       |                                                                                                                                   |      |      |                                                                                                                                     |                                                                  |  |
|-----------------------|-----------------------------------------------------------------------------------------------------------------------------------|------|------|-------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--|
| <b>Hearing Screen</b> | <input type="checkbox"/> Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.                                            |      |      | <input type="checkbox"/> Referred to Audiologist/ENT <input type="checkbox"/> Unable to Test – Needs Rescreen                       |                                                                  |  |
|                       | <input type="checkbox"/> Screened by OAE (Otoacoustic Emissions): <input type="checkbox"/> Pass <input type="checkbox"/> Referred |      |      | <input type="checkbox"/> Permanent Hearing Loss Previously Identified: <input type="checkbox"/> Left <input type="checkbox"/> Right |                                                                  |  |
|                       |                                                                                                                                   | 1000 | 2000 | 4000                                                                                                                                | <input type="checkbox"/> Hearing aid or another assistive device |  |
|                       | R                                                                                                                                 |      |      |                                                                                                                                     |                                                                  |  |
|                       | L                                                                                                                                 |      |      |                                                                                                                                     |                                                                  |  |

|                      |                                                                                                                                        |      |                                     |     |                      |                                                                                                                                                                                                                                                           |            |
|----------------------|----------------------------------------------------------------------------------------------------------------------------------------|------|-------------------------------------|-----|----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| <b>Vision Screen</b> | <input type="checkbox"/> With Corrective Lenses (Check if Yes)                                                                         |      |                                     |     | <b>Dental Screen</b> | <input type="checkbox"/> Problems Identified: Referred for Treatment<br><input type="checkbox"/> No Problem: Referred for prevention<br><input type="checkbox"/> No Referral: Already receiving dental care<br><input type="checkbox"/> Unable to perform |            |
|                      | Stereopsis: <input type="checkbox"/> Pass <input type="checkbox"/> Fail                                                                |      | <input type="checkbox"/> Not Tested |     |                      |                                                                                                                                                                                                                                                           |            |
|                      | Distance                                                                                                                               | Both | R                                   | L   |                      |                                                                                                                                                                                                                                                           | Test Used: |
|                      |                                                                                                                                        | 20/  | 20/                                 | 20/ |                      |                                                                                                                                                                                                                                                           |            |
|                      |                                                                                                                                        |      |                                     |     |                      |                                                                                                                                                                                                                                                           |            |
|                      | <input type="checkbox"/> Pass <input type="checkbox"/> Referred to Eye Doctor <input type="checkbox"/> Unable to Test - Needs Rescreen |      |                                     |     |                      |                                                                                                                                                                                                                                                           |            |

|                                                                                     |                                                                                                                                                                                                                                                   |  |
|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>Recommendations to (Pre) School, Child Care, or Early Intervention Personnel</b> | <b>Summary of Findings (check one):</b>                                                                                                                                                                                                           |  |
|                                                                                     | <input type="checkbox"/> Well child; no conditions identified of concern to school program activities                                                                                                                                             |  |
|                                                                                     | <input type="checkbox"/> Conditions identified that are important to schooling or physical activity (complete sections below and/or explain here): _____                                                                                          |  |
|                                                                                     | <input type="checkbox"/> Allergy: <input type="checkbox"/> Food: _____ <input type="checkbox"/> Insect: _____ <input type="checkbox"/> Medicine: _____ <input type="checkbox"/> Other: _____                                                      |  |
|                                                                                     | Type of allergic reaction: <input type="checkbox"/> anaphylaxis <input type="checkbox"/> local reaction Response required: <input type="checkbox"/> none <input type="checkbox"/> epinephrine auto-injector <input type="checkbox"/> other: _____ |  |
|                                                                                     | <input type="checkbox"/> Individualized Health Care Plan needed (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)                                                                                                                   |  |
|                                                                                     | <input type="checkbox"/> Restricted Activity (Specify): _____                                                                                                                                                                                     |  |
|                                                                                     | <input type="checkbox"/> Developmental Evaluation: <input type="checkbox"/> Has IEP <input type="checkbox"/> Further Evaluation Needed for: _____                                                                                                 |  |
|                                                                                     | <input type="checkbox"/> Medication: Child takes medicine for specific health condition(s). <input type="checkbox"/> Medication must be given and/or available at school.                                                                         |  |
|                                                                                     | <input type="checkbox"/> Special Diet (Specify): _____                                                                                                                                                                                            |  |
| <input type="checkbox"/> Special Needs (Specify): _____                             |                                                                                                                                                                                                                                                   |  |
| <input type="checkbox"/> 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: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_-\_\_\_\_-\_\_\_\_ Fax: \_\_\_\_-\_\_\_\_-\_\_\_\_ Email: \_\_\_\_\_