MANCOMUNIDAD DE VIRGINIA
FORMULARIO DE SALUD PARA EL INGRESO ESCOLAR
Formulario de información médica/Informe de examen físico integral/Certificación de vacunación

Parte I – FORMULARIO DE INFORMACIÓN MÉDICA

La ley estatal (Código de Virginia Ref. § 22.1-270) requiere que su hijo esté vacunado y reciba un examen físico integral antes de ingresar al kínder o escuela primaria pública. **El padre/madre o tutor completa esta página (Parte I) del formulario.** El proveedor médico completa la Parte II y la Parte III del formulario. Este formulario debe completarse no más de un año antes del ingreso de su hijo a la escuela.

Nombre de la escuela: ______________________ Grado actual: __________

Nombre del estudiante: ______________________
Apellido Nombre Segundo nombre

Fecha nacimiento del estudiante: ___/___/___ Sexo: _____ Estado o país de nacimiento: __________ Idioma principal que habla: __________

Dirección del estudiante __________ Ciudad __________ Estado __________ Código Postal __________

Nombre del padre/madre o tutor legal 1: __________ Teléfono: ___-___-___ Trabajo/celular: ___-___-___

Nombre del padre/madre o tutor legal 2: __________ Teléfono: ___-___-___ Trabajo/celular: ___-___-___

Contacto de emergencia: __________ Teléfono: ___-___-___ Trabajo/celular: ___-___-___

Preferencia de hospital: __________

Seguro médico del niño: Ninguno ☐ FAMIS Plus (Medicaid) ☐ FAMIS ☐ Privado/comercial/patrocinado por el empleador ☐ __________

Cuadro 1. Afecciones preexistentes

Afección	Sí	Comentarios	Afección	Sí	Comentarios
Alergias (alimentos, insectos, medicamentos,látex). Indique **alergias potencialmente mortales**:			Diabetes: Tipo 1		
			Diabetes: Tipo 2		
			Bomba de insulina		
Alergias (estacionales)			Traumatismo craneal, conmoción cerebral		
Asma o afecciones respiratorias			Afecciones auditivas o sordera		
Trastorno por déficit de atención/hiperactividad			Afecciones cardíacas		
Afecciones conductuales/psíquicas/sociales			Intoxicación con plomo		
Afecciones del desarrollo			Afecciones musculares		
Afecciones de la vejiga			Convulsiones		
Afecciones de sangrado			Anemia de células falciformes (no trazas)		
Afecciones intestinales			Afecciones del habla		
Parálisis cerebral			Lesión de la médula espinal		
Fibrosis quística			Cirugía		
Afecciones de la salud dental			Afecciones de la vista		

Describa cualquier otra información importante relacionada con la salud de su hijo (☐ Sonda de alimentación, ☐ Traqueostomía, ☐ Aporte suplementario de oxígeno, ☐ Audífonos, ☐ Aparato dental, Silla de ruedas, Hospitalizaciones, etc.):

Cuadro 2. Medicamentos

Enumere todos los medicamentos recetados, de emergencia, de venta libre y hierbas medicinales que su hijo toma con regularidad (hogar/escuela):

Nombre del medicamento	Dosis	Hora de administración (hogar/escuela)	Notas
1.			
2.			
3.			
4.			

Medicamentos adicionales (nombre, dosis, hora de administración, notas)

Marque aquí si desea discutir información confidencial con la enfermera de la escuela u otra autoridad escolar. ☐ Sí ☐ No Proporcione la siguiente información:

	Nombre	Teléfono	Fecha de la última cita
Pediatra/proveedor de atención primaria			
Especialista			
Dentista			
Trabajador del caso (si corresponde)			

Yo __________ (autorizo) (no autorizo) al proveedor de atención de salud de mi hijo y al proveedor de atención de salud designado en el entorno escolar para discutir las preocupaciones de salud de mi hijo o intercambiar información relacionada con este formulario. Esta autorización estará vigente hasta que usted la retire. Puede retirar su autorización en cualquier momento comunicándose con la escuela de su hijo. Cuando se divulga información del expediente de su hijo, la documentación de la divulgación se mantiene en el expediente académico o de salud de su hijo.

Firma del padre/madre o tutor legal: __________ Fecha: ___/___/___

Firma del intérprete: __________ Fecha: ___/___/___

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. Pre-Existing 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 (☐ Feeding tube , ☐ Trach , ☐ Oxygen support, ☐ Hearing aids, ☐ Dental appliance, ☐ 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:

	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

Check if the student's Immunization Records are attached using a separate form signed by HCP	☐

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 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. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box. Please contact your 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) ☐ 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 (*Mo., Day, Yr.*):** ___/___/____

Section II
Conditional Enrollment and Exemptions

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's 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. 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			

Tuberculosis Screening

Check the box that applies:

☐ 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: ☐ Negative ☐ Positive

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.

☐ Screened by OAE (Otoacoustic Emissions): ☐ Pass ☐ Referred

	1000	2000	4000
R			
L			

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

☐ Permanent Hearing Loss Previously identified: ☐ Left ☐ Right

☐ Hearing aid or another 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

☐ Problems Identified: Referred for Treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

☐ **Unable to perform**

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:** ______________________

Practice/Clinic Name: ______________________ **Address:** ______________________

Phone: ____-____-______ **Fax:** ____-____-______ **Email:** ______________________