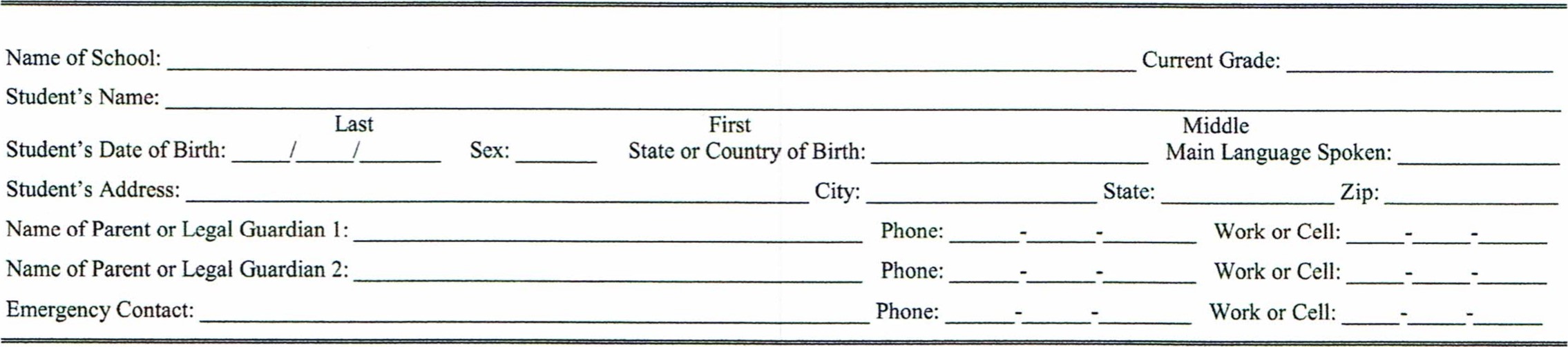
COMMONWEALTH OF VIRGINIA

SCHOOL ENTRANCE HEALTH FORM

Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization

# Part 1- 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 Il and Part Ill of the form. This form must be completed no longer than one year before your child's entry into school.



|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Condition | | | Yes | Comments | Condition | | | Yes | Comments |
| Aller •es food, insects, dru , latex | | |  |  | Diabetes | | |  |  |
| All ies seasonal | | |  |  | Head in • | | concussions |  |  |
| Asthma or breathin | | roblems |  |  | Hearin | | roblems or deaffess |  |  |
| Attention-Deficit/H | | eractivi Disorder |  |  | Heart roblems | | |  |  |
| Behavioral roblems | | |  |  | Lead isonin | | |  |  |
| Develo mental roblems | | |  |  | Muscle roblems | | |  |  |
| Bladder roblem | | |  |  | Seizures | | |  |  |
| Bleedin | roblem | |  |  | Sickle Cell Disease not trait | | |  |  |
| Bowel roblem | | |  |  | s | h roblems | |  |  |
| Cerebral Pals | | |  |  | S inal in' | | |  |  |
| C tic fibrosis | | |  |  | Sur e | | |  |  |
| Dental roblems | | |  |  | Vision roblems | | |  |  |

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. C Yes

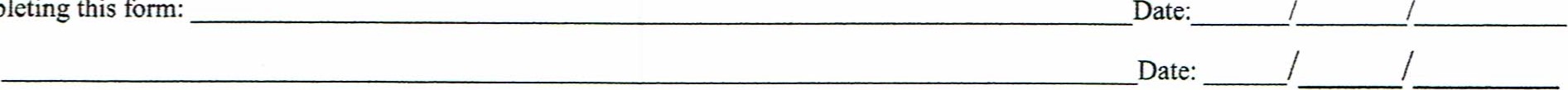
Please provide the following information:

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

Child's Health Insurance: None FAMIS Plus (Medicaid) FAMIS Private/CommercialÆmployer sponsored



|  |
| --- |
| 1,(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 inte by contacting your child's school. When information is releasedfrom your child's record, documentation ofthe disclosure is maintained in your child's health or scholastic record.  Signature of Parent or Legal Guardian: |

Signature of person completing this form:

Signature of Interpreter:

COMMONWEALTH OF VIRGINIA

SCHOOL ENTRANCE HEALTH FORM

Part Il - Certification of Immunization

Section I

To be completed by a physician or his designee, registered nurse, or health department official. See Section Il 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: I—I—I—I  Last First Middle Mo. Da 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 (6 grade entry) | 1 |  |  |  |  |
| \*Poliomyelitis (IPV, OPV) | 1 | 2 | 3 | 4 |  |
| \*Haemophilus influenzae Type b  (Hib conjugate)  \*onl 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 |
| 1 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 Regulationsfor the Immunization ofSchool Children (Reference Section Ill).  Signature of Medical Provider or Health Department Official: Date (Mo., Day, Yr.): | | | | | |

Student's Name:Date of Birth: I— L —1—-1

Section 11

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):        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, |

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-I), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. Code of Virginia S 22.1-271.2, C (i).

|  |  |
| --- | --- |
| CONDITIONAL ENROLLMENT: As specified in the Code of Viyginia 22.1-2712, 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, | |
| Section 111  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.) | |

Certification of Immunization 03/2014

# Part 111- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part Ill. 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 fom can be found at www.vahealth.org/schoolhealth.

Student's Name: Date of Birth: Sex: D M OF

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | Date of Assessment:  Weight: lbs. Height: ft. in.  Body  Mass  Age / gender appropriate history completed  Anticipatory guidance provided | | | | I = Within normal  1  HEENT  Lungs  Heart | | | Physical Examination  2 = Abnonnal finding 3 = Referred for evaluation or treatment  2 3 1 2 3 1 2 3  Neurological Skin  Abdomen Genital  D 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/H b | | | | | | | | | | | |
|  | | Assessed or: | | | | Assessm ent Method: | | Within normal | | | Concern identi ed: | | Re erred or Evaluation |
| Emotional/Social | | | |  | |  | | |  | |  |
| Problem Solving | | | |  | |  | | |  | |  |
| Language/Communication | | | |  | |  | | |  | |  |
| Fine Motor Skills | | | |  | |  | | |  | |  |
| Gross Motor Skills | | | |  | |  | | |  | |  |
|  | | | | Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.   |  |  |  |  | | --- | --- | --- | --- | |  | 1000 | 2000 | 4000 | |  |  |  |  | |  |  |  |  |   a Screened by OAE (Otoacoustic Emissions): Pass Refer | | | | | Referred to Audiologist/ENT c] Unable to test — needs rescreen  Permanent Hearing Loss Previously identified: Left Right  Hearing aid or other assistive device | | | | |
| |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | With Corrective Lenses check if es   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Stereo sis | a Pass |  | Fail |  |  | Not tested | | Distance | Both |  | |  | Test used: | | |  | 20/ | 20/ | | 20 |  | |   Pass Referred to eye doctor Unable to test — needs rescreen | | | | | | | | | | | | | | |  |  | | --- | --- | | 9 | Problem Identified: Referred for treatment  No Problem: Referred for prevention  No Referral: Already receiving dental care | | |
|  | | | | | | | 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):      Individualized Health Care Plan needed (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)  Restricted Activity Specify:  Developmental Evaluation  Medication. Child takes medicine for specific health condition(s). Medication must be given and/or available at school.  Special Diet Specify:  Special Needs Specifr•.  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:  Practice/Clinic Name: Address:  Phone:  Fax:  Email: | | | | | | | | | | | | | | | | |