

**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: _____
 Student's Date of Birth: _____ / _____ / _____ Sex: _____ State or Country of Birth: _____ Main Language Spoken: _____
 Student's Address: _____ City: _____ State: _____ Zip: _____
 Name of Mother or Legal Guardian: _____ Phone: _____ - _____ - _____ Work or Cell: _____ - _____ - _____
 Name of Father or Legal Guardian: _____ 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, 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
SCHOOL ENTRANCE HEALTH FORM**

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 (6 th 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 <2 years 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) <input type="checkbox"/> 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* (Minimum requirements are listed in 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 _____ <input type="checkbox"/> Age / gender appropriate history completed <input type="checkbox"/> Anticipatory guidance provided TB Risk Assessment: <input type="checkbox"/> No Risk <input type="checkbox"/> Positive/Referred Mantoux results: _____ mm	Physical Examination 1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment <table style="width:100%; border:none;"> <tr> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> </tr> <tr> <td>HEENT</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Neurological</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Skin</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Lungs</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Abdomen</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Genital</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Heart</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Extremities</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Urinary</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		1	2	3		1	2	3		1	2	3	HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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EPSDT Screens Required for Head Start – include specific results and date: Blood Lead: _____ Hct/Hgb _____																																																		

Developmental Screen	Assessed for:	Assessment Method:	<i>Within normal</i>	<i>Concern identified:</i>	<i>Referred for Evaluation</i>
	Emotional/Social				
	Problem Solving				
	Language/Communication				
	Fine Motor Skills				
Gross Motor Skills					

Hearing Screen	<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"/> Permanent Hearing Loss Previously identified: ___Left ___Right <input type="checkbox"/> Hearing aid or other assistive device												
	<table border="1" style="border-collapse: collapse;"> <tr> <td style="width:10%;"></td> <td style="width:15%;">1000</td> <td style="width:15%;">2000</td> <td style="width:15%;">4000</td> </tr> <tr> <td>R</td> <td></td> <td></td> <td></td> </tr> <tr> <td>L</td> <td></td> <td></td> <td></td> </tr> </table>		1000	2000	4000	R				L				
		1000	2000	4000										
R														
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<input type="checkbox"/> Screened by OAE (Otoacoustic Emissions): <input type="checkbox"/> Pass <input type="checkbox"/> Refer														

Vision Screen	<input type="checkbox"/> With Corrective Lenses (check if yes)			
	Stereopsis	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Not tested
	Distance	Both	R	L
		20/	20/	20/
<input type="checkbox"/> Pass <input type="checkbox"/> Referred to eye doctor <input type="checkbox"/> Unable to test – needs rescreen				

Dental Screen	<input type="checkbox"/> Problem Identified: Referred for treatment <input type="checkbox"/> No Problem: Referred for prevention <input type="checkbox"/> No Referral: Already receiving dental care
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Recommendations to (Pre) School, Child Care, or Early Intervention Personnel	Summary of Findings (check one): <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): _____ _____ _____ _____
	___ 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"/> epi pen <input type="checkbox"/> other: _____
	___ Individualized Health Care Plan needed (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)
	___ Restricted Activity Specify: _____
	___ Developmental Evaluation <input type="checkbox"/> Has IEP <input type="checkbox"/> Further evaluation needed for: _____
	___ Medication. Child takes medicine for specific health condition(s). <input type="checkbox"/> 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):			
Name : _____	Signature: _____	Date: ____/____/____	
Practice/Clinic Name: _____	Address: _____		
Phone: _____	Fax: _____	Email: _____	