

**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: _____ Middle 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 or spinal injury | | |
| Asthma or breathing problems | | | Hearing problems or deafness | | |
| Attention-Deficit/Hyperactivity Disorder | | | Heart problems | | |
| Behavioral problems | | | Hospitalizations | | |
| Developmental problems | | | Lead poisoning | | |
| Bladder problem | | | Muscle problems | | |
| Bleeding problem | | | Seizures | | |
| Bowel problem | | | Sickle Cell Disease (not trait) | | |
| Cerebral Palsy | | | Speech problems | | |
| Cystic fibrosis | | | Surgery | | |
| Dental problems | | | Vision problems | | |

Describe any other important health-related information about your child (for example, feeding tube, 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, 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 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:

| | | |
|--|--|--|
| | | |
|--|--|--|

| 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.):** ___ / ___ / ___

Section II
Conditional Enrollment and Exemptions

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

***Minimum Immunization Requirements for Entry into School and Day Care (requirements are subject to change)**

- 3 DTP or DTaP – at least one dose of DTaP or DTP after 4th birthday unless received 6 doses before 4th birthday
 - Tdap – booster required for entry into 6th grade if at least 5 years since last tetanus-containing vaccine
 - 3 Polio – at least one dose after 4th birthday unless received 4 doses of all OPV or all IPV prior to 4th birthday
 - Hib – 2-3 doses in infancy; 1 booster between 12-15 months; 1 dose between 15-60 months if unvaccinated, for children up to 60 months of age only
 - Pneumococcal – 2-4 doses, depending on age at 1st dose for children up to 2 years of age only
 - 2 Measles – 1st dose on/after 12 months of age; 2nd dose prior to entering kindergarten
 - 1 Mumps – on/after 12 months of age
 - 1 Rubella - on/after 12 months of age
- Note: Measles, Mumps, Rubella requirements also met with 2 MMR – 1st dose on/after 12 months of age; 2nd dose prior to entering kindergarten
- Hep B – 3 doses required (2 doses if Merck adult formulation given between 11 – 15 years of age; check the indicated box in Section I if this formulation was used)
 - 1 Varicella – to susceptible children born on/after January 1, 1997; dose on/after 12 months of age

*** Additional Immunizations Required at Entry into 6th Grade**

- Tdap – booster required for entry into 6th grade if at least 5 years since last tetanus-containing vaccine

For current requirements consult the Division of Immunization web site at <http://www.vdh.virginia.gov/epidemiology/immunization>

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"/> |
| | | 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"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EPSTD 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 | <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 |
| | | 1000 | 2000 | 4000 | |
| | R | | | | |
| | L | | | | |
| <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 | Test used: |
| | | 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 |
|----------------------|--|

| | |
|---|---|
| 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: _____ |
| | <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: _____ |
| | Other Comments: _____ _____ |

| | | |
|---|----------------------------|----------------------|
| Health Care Professional's Certification (Write legibly or stamp): | | |
| Name : _____ | Signature: _____ | Date: ____/____/____ |
| Practice/Clinic Name: _____ | Address: _____ | |
| Phone: _____ - _____ - _____ | Fax: _____ - _____ - _____ | Email: _____ |