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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:
____ Last First
Middle

Student's Date of Birth: _____/_____/_______ Sex: _______ State or Country of Birth: ____________________ Main Language Spoken: ______________

Student's Address: ____ City: ________________ State: ____________ Zip:

_______________ 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:

_____-_____-______

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, 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. •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: ______/______/_________

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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		
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	1	2
*Tdap booster (6th grade entry)	1	
*Poliomyelitis (IPV, OPV)	1	2
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age	1	2

*Pneumococcal (PCV conjugate) *only for children <60 months of age	1	2
Measles, Mumps, Rubella (MMR vaccine)	1	2
*Measles (Rubeola)	1	2
*Rubella	1	
*Mumps	1	2
*Hepatitis B Vaccine (HBV) ❑ Merck adult formulation used	1	2
*Varicella Vaccine		

Hepatitis A Vaccine	1	2
Meningococcal Vaccine	1	2
Human Papillomavirus Vaccine	1	
Other	1	2
Other	1	2
Other	1	2
I certify that this child is **ADEQ** **APPROPRIAT**	1	2

5

5

5

*** Required vaccine**
care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Reference Section III).

5

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Signature of Medical Provider or Health Department Official: Date (*Mo., Day, Yr*.):___/___/____Certification of Immunization 11/06

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

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 □ □ □

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/Hgb ____

Assessed for:	*Assessment Method:*	*Within normal*	*Concern identified:*	*Referred for 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

R

L

❑ Screened by OAE (Otoacoustic Emissions): □ Pass □ Refer

□ Referred to Audiologist/ENT □ **Unable to test – needs rescreen** □ Permanent Hearing Loss Previously identified: ___Left ___Right □ Hearing aid or other assistive device

❑ 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 res**

Summary of Findings (check one):

	❑ Problem Identified: Referred for treatment ❑ No Problem: Referred for prevention ❑ No Referral: Already receiving dental care

□ 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:** ____ Date: ____/_____/______

Practice/Clinic Name: ____ **Address**:
____ **Phone**: _______-_______-____________________ **Fax**:
_______-_______-______________ **Email:** ____