# 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:				76.	1 11
Student's Date of Birth:/	Cour	First State or Countr	v of Right	Mid Main	
Student's Address:					
Name of Mother or Legal Guardian:			Phone:		Work or Cell:
Name of Father or Legal Guardian:			Phone:		Work or Cell:
Emergency Contact:		4	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 de	eafness	
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Hospitalizations		
Developmental problems			Lead poisoning		
Bladder problem			Muscle problems		
Bleeding problem			Seizures		
Bowel problem		The state of the s	Sickle Cell Disease (no	it trait)	
Cerebral Palsy			Speech problems		
Cystic fibrosis			Surgery Vision problems		
				ort, hearing aid, e	etc.):
List all prescription, over-the-counter, and	herbal medica	ttions your child takes reg	ularly:		etc.):
List all prescription, over-the-counter, and	herbal medica	ttions your child takes reg	ularly: r other school authority.  ☐ Yes		
List all prescription, over-the-counter, and  Check here if you want to discuss confident  Please provide the following information:	herbal medica	ttions your child takes reg	ularly:		Date of Last Appointme
List all prescription, over-the-counter, and  Check here if you want to discuss confident  Please provide the following information:	herbal medica	ntions your child takes reg	ularly: r other school authority.  ☐ Yes		
List all prescription, over-the-counter, and  Check here if you want to discuss confident  Please provide the following information:  Pediatrician/primary care provider	herbal medica	ntions your child takes reg	ularly: r other school authority.  ☐ Yes		
List all prescription, over-the-counter, and  Check here if you want to discuss confident Please provide the following information:  Pediatrician/primary care provider  Specialist	herbal medica	ntions your child takes reg	ularly: r other school authority.  ☐ Yes		
List all prescription, over-the-counter, and  Check here if you want to discuss confident Please provide the following information:  Pediatrician/primary care provider  Specialist  Dentist  Case Worker (if applicable)	herbal medica	ntions your child takes reg	ularly: r other school authority.  ☐ Yes		
List all prescription, over-the-counter, and  Check here if you want to discuss confident Please provide the following information:  Pediatrician/primary care provider  Specialist  Dentist	herbal medica	ntions your child takes reg	r other school authority.   Phone	s 🗆 No	
List all prescription, over-the-counter, and  Check here if you want to discuss confident Please provide the following information:  Pediatrician/primary care provider  Specialist  Dentist  Case Worker (if applicable)	herbal medical tial information from the families of the famil	n with the school nurse of Name  S Plus (Medicaid)  (do not) authorize d/or exchange informating time by contacting you ild's health or scholastic	pularly:  r other school authority.	e/Commercial/En	Date of Last Appointme  mployer sponsored  d provider of health care in will be in place until or unle
List all prescription, over-the-counter, and  Check here if you want to discuss confident Please provide the following information:  Pediatrician/primary care provider  Specialist  Dentist  Case Worker (if applicable)  Child's Health Insurance: None  I, school setting to discuss my child's health withdraw it. You may withdraw your auth documentation of the disclosure is maintain	herbal medical tial information from the families of the famil	n with the school nurse of Name  S Plus (Medicaid)  (do not) authorize d/or exchange informating time by contacting you ild's health or scholastic	pularly:  r other school authority.	e/Commercial/En	Date of Last Appointme  mployer sponsored  ed provider of health care in will be in place until or unle from your child's record,
List all prescription, over-the-counter, and  Check here if you want to discuss confident Please provide the following information:  Pediatrician/primary care provider  Specialist  Dentist  Case Worker (if applicable)  Child's Health Insurance: None  I, school setting to discuss my child's health withdraw it. You may withdraw your auth documentation of the disclosure is maintain	herbal medical tial information from the family of the fam	Name  S Plus (Medicaid)  (do not) authorize dor exchange informating time by contacting you ilid's health or scholastic	pularly:  Phone  Phone  FAMIS Private  my child's health care provide ion pertaining to this form. The child's school. When informative cord.	e/Commercial/En	Date of Last Appointme  mployer sponsored  ed provider of health care in will be in place until or unle from your child's record,

## 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.

Last		First	The second design of the second secon	Date of Bir 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 <sup>th</sup> 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	The Line					
*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)  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					

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Section II							
	Conditional Enrollment and Exemptions						
MEDICAL detrimental	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 to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):						
	Tdap:[]; DT/Td:[]; OPV/IPV:[]; Hib:[]; Pneum:[]; Measles:[]; Rubella:[]; Mumps:[]; HBV:[]; Varicella:[]						
This contrai	indication is permanent: [], or temporary [] and expected to preclude immunizations until: Date (Mo., Day, Yr.):						
Signature o	of Medical Provider or Health Department Official: Date (Mo., Day, Yr.):						
student's pa	US EXEMPTION: The <i>Code of Virginia</i> allows a child an exemption from receiving immunizations required for school attendance if the student or the arent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious actices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at ealth department, school division superintendent's office or local department of social services. Ref. <i>Code of Virginia</i> § 22.1-271.2, C (i).						
CONDITION required by immunization	ONAL ENROLLMENT: As specified in the <i>Code of Virginia</i> § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines 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 on due on						
Signature o	of Medical Provider or Health Department Official: Date (Mo., Day, Yr.):  _						
	Section III						
	Requirements						
*Minim	um 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 4 <sup>th</sup> birthday unless received 6 doses before 4 <sup>th</sup> birthday Tdap – booster required for entry into 6 <sup>th</sup> grade if at least 5 years since last tetanus-containing vaccine 3 Polio – at least one dose after 4 <sup>th</sup> birthday unless received 4 doses of all OPV or all IPV prior to 4 <sup>th</sup> 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 1 <sup>st</sup> dose for children up to 2 years of age only						
	2 Measles – 1 <sup>st</sup> dose on/after 12 months of age; 2 <sup>nd</sup> 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 – 1 <sup>st</sup> dose on/after 12 months of age; 2 <sup>nd</sup> 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						
* Addit	ional Immunizations Required at Entry into 6 <sup>th</sup> Grade						
÷, a	Tdap - booster required for entry into 6th grade if at least 5 years since last tetanus-containing vaccine						
- 4	ent requirements consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization						

\_\_\_\_\_Date of Birth: |\_\_\_\_\_

Certification of Immunization 04/07

Student's Name:\_

### 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	s Name:	Da	te of Birth:	/_		/				(: ⊔ M	<u> </u>			$\neg$	
1.0%	8 ( 5 )					Physical Ex						1 6			
ssment	Date of Assessment: / /		1 = Within normal 2			normal finding				for evaluat					
			1	2	3		1	2	3		1	2	3		
	Body Mass Index (BMI): BP	HE	ENT $\Box$			Neurological				Skin			D		
	☐ Age / gender appropriate history completed	Lun	gs 🗆			Abdomen				Genital					
(=)	☐ Anticipatory guidance provided	Hea	rt 🗆			Extremities	П			Urinary					
eal	TB Risk Assessment: □ No Risk □ Positive/Referred	1100			_	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			_					K.	
=	Mantoux results: mm	a waanita c	and datas											-	
and the state of t	EPSDT Screens Required for Head Start – include specific results and date:    Het/Hgb														
				, ,		·	1	^ 1		D -C	J.C	Eva	luation		
-	Assessed for: Assessment Method:  Emotional/Social		Within normal			Concern identified:					Referred for Evaluation				
nta									W-134441					$\dashv$	
een	Problem Solving				1000									$\dashv$	
clopme	Language/Communication													-	
Developmental Screen	Fine Motor Skills													_	
	Gross Motor Skills														
		econolis												$\neg$	
	☐ Screened at 20dB: Indicate Pass (P) or Refer (R) in each be	ox.													
Hearing Screen	1000 2000 4000		☐ Referred to Audiologist/ENT ☐ Unable to test – needs rescreen												
	R		□ Pe	manent	t He	aring Loss Prev	iously	/ iden	itified:	Le	ì.	Rig	ght		
He	L		□ Не	aring ai	id or	other assistive	devic	e							
	☐ Screened by OAE (Otoacoustic Emissions): ☐ Pass ☐ Refer														
			-		_									$\neg$	
	☐ With Corrective Lenses (check if yes)  Stereopsis ☐ Pass ☐ Fail ☐ No	ot tested		- 1			7 D	L1	Idonti	God, Dofa	wend .	for trac	tmant		
on max	Distance Both R L Test u		sed.												
Vision Screen	20/ 20/ 20/	No Problem: Referred for prevention  No Referral: Already receiving dental care													
		ole to test	– needs reso	reen			■ No	Refe	erral: .	Already re	ceivii	ng den	tai car	2	
>	Summary of Findings (check one):														
Sarl	☐ 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):														
or I	Conditions identified that are important to schooling of physical activity (complete sections only allow explain here).										-				
ild Care, or Early el														-	
Ö														-	
												à		-	
Recommendations to (Pre) School , Ch Intervention Personn	Allergy □ food: □ insect:		☐ medicine: ☐ other: ☐												
cho	Type of allergic reaction:   anaphylaxis   local reaction   Response required:   none   epi pen   other:														
e) S	Individualized Health Care Plan needed (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)														
ns to (Pre) Sc Intervention	Restricted Activity Specify:														
ns to Inte	Developmental Evaluation														
ıtioı	Medication. Child takes medicine for specific health condition(s).														
spus															
ĬII.	Special Diet Specify:														
ec01	Special Needs Specify:									-					
2	Other Comments:													]	
Health	Care Professional's Certification (Write legibly or stamp				9										
			gnature:							Date:				_	
Practice	e/Clinic Name:	A				E									
Phone:	Fax:					Email:		W. 2011		************					

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