Signature of Interpreter:

# COMMONWEALTH OF VIRGINIA SCHOOL ENTRANCE HEALTH FORM

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

#### Part I – <u>HEALTH INFORMATION FORM</u>

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:				Gra	nde:			
Student's Name:								
Last		First		Mid				
Student's Date of Birth://					Language Spoken:			
Student's Address:			_ City: Stat	e:	Zip:			
Name of Mother or Legal Guardian:			Phone:		Work or Cell:			
Name of Father or Legal Guardian:								
Emergency Contact:		Work or Cell:						
Emergency Contact.			Thone.		work of Cen.			
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  Developmental problems			Hospitalizations 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					
List all prescription, over-the-counter, and	herbal medic	cations your child takes regular	rly:					
Check here if you want to discuss confiden		on with the school nurse or oth	her school authority.   Yes	□No				
Please provide the following information:								
Pediatrician/primary care provider		Name	Phone	Date of Last Appointment				
Specialist Specialist								
Dentist								
Case Worker (if applicable)								
Child's Health Insurance: None	FAM	IS Plus (Medicaid) F	FAMIS Private/Comm	ercial/En	nployer sponsored			
					_			
I, school setting to discuss my child's health withdraw it. You may withdraw your auth documentation of the disclosure is maintain	h concerns a <i>orization at d</i>	nd/or exchange information any time by contacting your cl	pertaining to this form. This autho hild's school. When information is r	rization	will be in place until or unless you			
Signature of Parent or Legal Guardian:				Da	te:/			
Signature of person completing this form:				Dat	te:/			

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# 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.

tudent's Name:	irst	Date of Birth:        Middle Mo. Day Yr.									
IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN										
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	5								
*Diphtheria, Tetanus (DT) or Td (given after 7 /ears of age)	1	2	3	4	5						
Tdap booster (6 <sup>th</sup> grade entry)	1										
Poliomyelitis (IPV, OPV)	1	2	3	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		1							
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:								
Iepatitis 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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Student's Name: Date of	Birth:	
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### Section II Conditional Enrollment and Exemptions

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):								
$DTP/DTaP/Tdap: \cite{thm:below:continuous}; \ DT/Td: \cite{thm:below:continuous}; \ Pneum: \cite{thm:below:continuous}; \ Measles: \cite{thm:below:continuous}; \ Mumps: \cite{thm:below:continuous}; \ HBV: \cite{thm:below:continuous}; \ HBV: \cite{thm:below:continuous}; \ Varicella: \cite{thm:below:continuous}; \ Mumps: \cite{thm:below:continuous}; \ Mumps: \cite{thm:below:continuous}; \ HBV: \cite{thm:below:continuous}; \ Mumps: thm:below$								
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.):								
<b>RELIGIOUS EXEMPTION:</b> The <i>Code of Virginia</i> 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 a any local health department, school division superintendent's office or local department of social services. Ref. <i>Code of Virginia</i> § 22.1-271.2, C (i).								
CONDITIONAL 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 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								
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 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  Measles – 1 <sup>st</sup> dose on/after 12 months of age; 2 <sup>nd</sup> dose prior to entering kindergarten								
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### 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	Date of Birth:        //         Sex:         □ M         □ F											
	Data of Assessments			Physical Examination										
	Date of Assessment:        //           Weight:        / ft.         in			Vithin normal	2 = A	Abnormal findin	ng 3 =	= Refe	erred f	for evaluat	tion o	r treat	tment	
nen				1	2 3	i	1	2	3		1	2	3	
essr	Body Mass Index (BMI) – for age: BP			ENT 🗆		Neurologica	al 🗆			Skin				
Ass	☐ Age / gender appropriate history completed			ngs 🗆		Abdomen				Genital				
lth .	☐ Anticipatory guidance provided			art 🗆	0 0	Extremities				Urinary				
Health Assessment	TB Risk Assessment: □ No Risk □ Positive/Referred			_			_	_	_	- ,	_			
	Mantoux results:  EPSDT Screens Required for He	mm ead Start – include specifi	fic results :	results and date:										
	Blood Lead: Hct/Hgb													
	Assessed for: Assessment Method: Within normal Concern identified: Referred for Evaluation										aluation			
tal	Emotional/Social	Algorithm 1.2		77.00		Concern tacinifica.					, ,		in become a	
nent en	Problem Solving									1				
Developmental Screen	Language/Communication													
evel	Fine Motor Skills			<del> </del>						-				
Ď	Gross Motor Skills									-				
<u> </u>		<u> </u>		<u> </u>	L									
	☐ Screened at 20dB: Indicate Pass	s (P) or Refer (R) in each	box.											
2 u	1000 2000 4000			□ Referred to Audiologist/ENT □ Unable to test – needs rescreen										
Hearing Screen	R			□ Pen	Hearing Loss Pre	Hearing Loss Previously identified:LeftRight						ght		
He	L			☐ Hearing aid or other assistive device										
	☐ Screened by OAE (Otoacoustic	Refer												
	□ With Glasses (check if yes)         Stereopsis       □ Pass       □ Fail       □ Not										1.0			
Vision Screen	Distance Both R L Test us					Dental		☐ Problem Identified: Referred for treatmen						
Vision Screen	20/ 20	20/ 20/				Dental Screen		<ul><li>No Problem: Referred for prevention</li><li>No Referral: Already receiving dental car</li></ul>						
	☐ Pass ☐ Referred to	eye doctor Una	ble to test	– needs resci	reen		☐ No	Refe	rral: A	Already re	ceivir	ıg der	ıtal care	
						J L								
.ly	Summary of Findings (check one Well child: no conditions ident		ol nrogram	activities										
Recommendations to (Pre) School , Child Care, or Early Intervention Personnel	□ 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):													
e, or														
Car														
nild nel														
, CI som	Sound													
hool Per	Allergy □ food: Type of allergic reaction: □ an	insect:	Dagno		□ medic	ine:	athar		_ <sup>_</sup> 0	ther:				
Scl	Individualized Health Care P						ouici.							
ns to (Pre) Sc Intervention	Restricted Activity Specify:	( 8 / /	,		,	037 7								
s to nter														
tion	Developmental Evaluation													
enda	Medication. Child takes medi	•	` ′			ation must be gi								
m H	Special Diet Specify:													
(eco	Special Needs Specify:													
<u> </u>	Other Comments:													
Health	Care Professional's Certificati	ion (Write legibly or stam	np):											
Name:			Siş	gnature:						Date: _	/_		/	
Practice	e/Clinic Name:		A	ddress:										
Phone:		Fax: -												

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