

**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 earlier 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 Code _____

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: _____ - _____ - _____

Hospital Preference: _____

Child's Health Insurance: None ☐ FAMIS Plus (Medicaid) ☐ FAMIS ☐ Private/Commercial/ Employer Sponsored ☐

Box 1. Pre-Existing Conditions

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes: Type 1		
Please list Life Threatening Allergies:			Diabetes: Type 2		
			Insulin pump		
Allergies (seasonal)			Head injury, concussion		
Asthma or breathing conditions			Hearing conditions or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart conditions		
Behavioral/Psych/ Social conditions			Lead poisoning		
Developmental conditions			Muscle conditions		
Bladder conditions			Seizures		
Bleeding conditions			Sickle Cell Disease (not trait)		
Bowel conditions			Speech conditions		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental Health conditions			Vision conditions		

Describe any other important health-related information about your child (☐ Feeding tube, ☐ Trach, ☐ Oxygen support, ☐ Hearing aids, ☐ Dental appliance, ☐ Wheelchair, Hospitalizations, etc.):

Box 2. Medications

List all prescription, emergency, over-the-counter, and herbal medications your child takes regularly (Home/ School):

Medication Name	Dosage	Time Administered (Home/School)	Notes
1.			
2.			
3.			
4.			

Additional Medications (Name, Dose, Time Administered, Notes)

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)		

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 Interpreter: _____ **Date:** ____/____/____

**COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Part II - Certification of Immunization**

Check if the student's
Immunization
Records are attached
using a separate form
signed by HCP

☐

Section I

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. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box. Please contact your local health department for assistance with foreign vaccine records.

Student Name: _____ **Date of Birth :** / / **Sex:** _____
Race (Optional): _____ **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
Diphtheria, Tetanus, Pertussis Vaccine (DTP, DTaP)	1	2	3	4	5
Diphtheria, Tetanus (DT) or Tdap or Td Vaccine (given after 7 years of age)	1	2	3	4	5
Tdap Vaccine booster	1				
Poliomyelitis Vaccine (IPV, OPV)	1	2	3	4	5
Haemophilus influenzae Type b Vaccine (Hib conjugate) only for children <60 months of age	1	2	3	4	
Rotavirus Vaccine (RV) only for children < 8 months of age	1	2	3		
Pneumococcal Vaccine (PCV conjugate) only for children <60 months of age	1	2	3	4	
Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Measles, Mumps, Rubella Vaccine (MMR vaccine)	1	2			
Measles Vaccine (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
Rubella Vaccine	1	2	Serological Confirmation of Rubella Immunity:		
Mumps Vaccine	1	2	Serological Confirmation of Mumps Immunity:		
Hepatitis B Vaccine (HBV) ☐ Merck adult formulation used	1	2	3	4	
Hepatitis A Vaccine	1	2			
Meningococcal ACWY Vaccine	1	2			
Meningococcal B Vaccine	1	2	3		
Human Papillomavirus Vaccine (HPV)	1	2	3		
Influenza (Yearly)	1	2	3	4	5
Other	1	2	3	4	5
Other	1	2	3	4	5

Certification of Immunization

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* (Reference Section III).

Signature of Medical Provider or Health Department Official: _____

Date (Mo., Day, Yr.): 12 / /

Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date.
This section must be attached to Part I Health Information (to be filled out and signed by parent).

Student's Name: _____ Date of Birth:

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Parent or Legal Guardian Name: _____
Parent or Legal Guardian Name: _____
Phone Number: _____

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:[

--

]; PCV:[

--

]; RV:[

--

]; Measles :[

--

];

Mumps:[

--

]; Rubella :[

--

]; VAR:[

--

]; Men ACWY:[

--

]; Men B:[

--

]; Hep A:[

--

]; HBV:[

--

]

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.):

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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.):

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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 ____ ☐ Age / gender appropriate history completed ☐ Anticipatory guidance provided	Physical Examination 1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <th></th><th>1</th><th>2</th><th>3</th><th></th><th>1</th><th>2</th><th>3</th><th></th><th>1</th><th>2</th><th>3</th></tr> <tr> <td>HEENT</td><td></td><td></td><td></td><td>Neurological</td><td></td><td></td><td></td><td>Skin</td><td></td><td></td><td></td></tr> <tr> <td>Lungs</td><td></td><td></td><td></td><td>Abdomen</td><td></td><td></td><td></td><td>Genital</td><td></td><td></td><td></td></tr> <tr> <td>Heart</td><td></td><td></td><td></td><td>Extremities</td><td></td><td></td><td></td><td>Urinary</td><td></td><td></td><td></td></tr> </table>		1	2	3		1	2	3		1	2	3	HEENT				Neurological				Skin				Lungs				Abdomen				Genital				Heart				Extremities				Urinary			
		1	2	3		1	2	3		1	2	3																																						
	HEENT				Neurological				Skin																																									
	Lungs				Abdomen				Genital																																									
	Heart				Extremities				Urinary																																									
	Tuberculosis Screening																																																	
Check the box that applies: ☐ 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: ☐ Negative ☐ Positive 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 _____																																																		

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	☐ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box. ☐ Screened by OAE (Otoacoustic Emissions): ☐ Pass ☐ Referred				☐ Referred to Audiologist/ENT ☐ Unable to test – needs rescreen ☐ Permanent Hearing Loss Previously identified: ☐ Left ☐ Right ☐ Hearing aid or another assistive device
		1000	2000	4000	
	R				
	L				

Vision Screen	☐ With Corrective Lenses (Check if yes) <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td colspan="4">Stereopsis ☐ Pass ☐ Fail ☐ Not tested</td> </tr> <tr> <td>Distance</td><td>Both</td><td>R</td><td>L</td> </tr> <tr> <td></td><td>20/</td><td>20/</td><td>20/</td> </tr> </table>	Stereopsis ☐ Pass ☐ Fail ☐ Not tested				Distance	Both	R	L		20/	20/	20/	☐ Pass ☐ Referred to eye doctor ☐ Unable to test-needs rescreen	Dental Screen ☐ Problems Identified: Referred for Treatment ☐ No Problem: Referred for prevention ☐ No Referral: Already receiving dental care ☐ Unable to perform
	Stereopsis ☐ Pass ☐ Fail ☐ Not tested														
	Distance	Both	R	L											
		20/	20/	20/											

Recommendations to (Pre) School, Child Care, or Early Intervention Personnel	Summary of Findings (check one): ☐ 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: _____
 Practice/Clinic Name: _____ Address: _____
 Phone: ____ - ____ - ____ Fax: ____ - ____ - ____ Email: _____