

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. PreExisting 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:

Type	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: ____/____/____

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Part II – Certification of Immunization

A copy of child's
immunization records
is attached

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 official of health department indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording the dates on this page, as long as the completed immunization record is attached to the School Entrance Health Form: Part II Certification of Immunization (MCH213G).

As per 12VAC5-110-70, the Certification of Immunization form must be signed and dated by the Medical Provider (physician or designee, registered nurse, or official of the health department) in the appropriate box below. Contact 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				
	1	2	3	4	5
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: ____/____/____

Section II Conditional Enrollment and Exemptions

A qualified licensed physician, nurse practitioner, or physician assistant must 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 Name: _____ Date of Birth: ____/____/____

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.):** ____/____/____

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 (or 180 days for Hepatitis B). **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 <https://www.vdh.virginia.gov/immunization/requirements>

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 and sign 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.vdh.virginia.gov/school-age-health-and-forms/school-health-forms-and-action-plans

Student 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								
		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 Screenshot	Assessed for:	Assessment Method:	Within Normal	Concern Identified:	Referred for Evaluation
	Emotional/Social				
	Problem Solving				
	Language/Communication				
	Fine Motor Skills				
	Gross Motor Skills				

Hearing Screenshot	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 Screenshot	With Corrective Lenses (Check if Yes)				Dental Screenshot	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			Test Used:
		20/	20/	20/			
Pass Referred to Eye Doctor Unable to Test - Needs Rescreen							

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: _____ <i>Type of allergic reaction: anaphylaxis local reaction Response required: none epinephrine auto-injector other: _____</i>
	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: _____ Address: _____

Phone: ____-____-____ Fax: ____-____-____ Email: _____