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				
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 – Certification of Immunization

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 Sceeen

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

Hearing Sceeen

☐ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.

☐ Screened by OAE (Otoacoustic Emissions): ☐ Pass ☐ Referred

	1000	2000	4000
R			
L			

☐ Referred to Audiologist/ENT ☐ **Unable to Test — Needs Rescreen**

☐ Permanent Hearing Loss Previously Identified: ☐ Left ☐ Right

☐ Hearing aid or another assistive device

Vision Sceeen

☐ With Corrective Lenses (Check if Yes)

Stereopsis: ☐ Pass ☐ Fail ☐ Not Tested

Distance	Both	R	L
	20/	20/	20/

Test Used:

☐ Pass ☐ Referred to Eye Doctor ☐ Unable to Test - Needs Rescreen

Dental Sceeen

☐ Problems Identified: Referred for Treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

☐ **Unable to perform**

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: _____ Date: ____/____/_____

Practice/Clinic: _____ Address: _____

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