# 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:					•				
Last		Middle							
	/ Sex: State or Country of Birth:								
Student's Address:	ent's Address: City: Sta								
Name of Mother or Legal Guardian:			Phone:	***************************************	Work or Cell:				
Name of Father or Legal Guardian:			Phone:		Work or Cell:				
Emergency Contact:		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 deafness						
Attention-Deficit/Hyperactivity Disorder			Heart problems						
Behavioral problems			Hospitalizations						
Developmental problems			Lead poisoning						
Bladder problem	<del></del>		Muscle problems						
Bleeding problem	1		Seizures						
Bowel problem	1		Sickle Cell Disease (not trait)	_					
Cerebral Palsy			Speech problems						
Cystic fibrosis	+		Surgery	<b> </b>					
Dental problems	+		Vision problems						
List all prescription, over-the-counter, and herbal medications your child takes regularly:  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)	,								
Child's Health Insurance: None	FAMIS	S Plus (Medicaid)	FAMIS Private/Comme	rcial/Er	nployer sponsored				
I,	concerns an orization at an ed in your chi	d/or exchange information ny time by contacting your ild's health or scholastic rec	<b>child's school</b> . When information is record.	rization eleased	will be in place until or unless you				
Signature of person completing this form:				Da	te: / /				
			•	ъ.					
Signature of Interpreter:			TANDINA OPPORTUNITA DE LA CASTA DEL CASTA DE LA CASTA DEL CASTA DE LA CASTA DE	Da	ne:/				

MCH 213 F revised 4/07

## 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.

Student's Name:				Date of Birth:						
Last	Firs	1	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						
*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 Confirmat	tion of Measles Immunity:						
*Rubella	1		Serological Confirmat	ion of Rubella Immunity:						
*Mumps	1	2								
*Hepatitis B Vaccine (HBV)  Merck adult formulation used	1	2	3		,					
*Varicella Vaccine	1	2	Date of Varicella Dise Immunity:	ase OR Serological Confir	mation of Varicella					
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					
I certify that this child is ADEQUATELY OR A care or preschool prescribed by the State Board of	f Health's Regulation	s for the Immunization	of School Children (Min	imum requirements are list	ed in Section III).					
Signature of Medical Provider or Health Depa	TOBERT Official:			лакс ( <i>ти., Day, II</i> .):/						

MCH 213 F revised 4/07

Student's Name:Date of Birth:	
Section II  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:[]; DT/Td:[]; OPV/IPV:[]; Hib:[]; Pneum:[]; Measles:[]; Rubella:[]; Mumps:[]; HBV:[]; Varicella:[]	<u></u>
This contraindication is permanent: [], or temporary [] and expected to preclude immunizations until: Date (Mo., Day, Yr.): .  Signature of Medical Provider or Health Department Official:	
<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 relig tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtain 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).	ious ned at
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 vacci 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. immunization due on  Signature of Medical Provider or Health Department Official: Date (Mo., Day, Yr.):	
Section III 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 under the content of the content o	n to
60 months of age only	ւթ ւ
Pneumococcal – 2-4 doses, depending on age at 1 <sup>st</sup> dose for children up to 2 years of age only	
<ul> <li>□ 2 Measles - 1<sup>st</sup> dose on/after 12 months of age; 2<sup>nd</sup> dose prior to entering kindergarten</li> <li>□ 1 Mumps - on/after 12 months of age</li> </ul>	
☐ 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	<b>)</b>
entering kindergarten  Hep B – 3 doses required (2 doses if Merck adult formulation given between 11 – 15 years of age; check the indicated box	cin
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	
* Additional Immunizations Required at Entry into 6 <sup>th</sup> Grade	
☐ Tdap – booster required for entry into 6 <sup>th</sup> grade if at least 5 years since last tetanus-containing vaccine	
For current requirements consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization	n

Certification of Immunization 04/07

MCH 213 F revised 4/07

### 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: DM DF										
Date of Assessment:/			Physical Examination										
			1 = Within normal 2 =			- Abı	normal finding	3 = Referred for evaluation or treatment					
mer	Weight:lbs. Height:ftin.			1	2	3		1	2	3	1	2	3
Weight: ibs. Height: ft in.  Body Mass Index (BMI): BP  Age / gender appropriate history completed  Anticipatory guidance provided  TB Risk Assessment: No Risk Positive/Referred			HEE	ENT			Neurological			□ Skin			
AS	Age / gender appropriate history completed			gs 🗆			Abdomen			☐ Genital			
alth	☐ Anticipatory guidance provide		Hear	rt 🗆			Extremities			□ Urinary			
He	TB Risk Assessment: □ No Ris Mantoux results:	Mm □ Positive/Referred											
	EPSDT Screens Required for He		results a					<b></b>					
Blood Lead: Hct/Hgb													
	Assessed for: Assessment Method:			Within normal			Concern ia	lentifie	d:	Refer	Referred for Evaluation		
Developmental Screen	Emotional/Social												
een	Problem Solving												
elopme Screen	Language/Communication												
)evi	Fine Motor Skills												
	Gross Motor Skills								•				
	☐ Screened at 20dB: Indicate Pas	s (P) or Refer (R) in each ho	v										
		000 4000	Λ,	□ Ref	erred to	о Ап	diologist/ENT		n Un	able to test –	haar	race	roon
Hearing Screen	R	4000					•						
Hearing Screen	L						aring Loss Previ		gentif	ried:Lei	t -	Ri	ght
-	☐ Screened by OAE (Otoacoustic	Emissions):  Pass  R	efer	□ Hea	rıng aı	id or	other assistive of	device					
			~~ <del>***********************************</del>										
	☐ With Corrective Lenses (check												
u u	Stereopsis Pass Distance Both R	Fail Not L Test us					<b>∃</b> 5 □	Probl	em Id	lentified: Refe	Referred for treatment		
Vision Screen		0/ 20/	ed:  Details and the problem Identified  Problem Identified  No Problem: Refer						m: Referred fo	erred for prevention			
- S	□ Pass □ Referred to eye doctor □ Unable to test ~ needs rescreen □ No Referral: Already receiving dental care									ntal care			
	arass arciciled to	Cyc doctor — Chapte	e to test	- needs reser	cen								
À	Summary of Findings (check one Well child; no conditions ident			aatluitias								101	
Care, or Early	□ Conditions identified that are				plete s	sectio	ons below and/o	r expla	in her	re):			
, or	MARK 1111												
Care													<del></del>
T				······									
, Chil	Succession	· · · · · · · · · · · · · · · · · · ·							_				***************************************
School on Pers	Allergy   food:   insect:   medicine:   dother:												
Type of altergic reaction:   anaphytaxis   local reaction   Response required.   I note   epi pen   Joiner:													
(Pre vent	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:												
s to	Restricted Activity Specify:			1.16									
o bottophical 2 data and 1 data a													
Medication. Child takes medicine for specific health condition(s).													
nme	Special Diet Specify:												
ecor	Special Needs Specify:						<u>.</u>						
~	Other Comments:												
Health Care Professional's Certification (Write legibly or stamp):													
Name: Date:													
Practice/Clinic Name:,,													
Phone:		Fax:											

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