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:				Current	Grade:
				Current	Grade.
Student's Name:		F:		Mic	1.11.
Student's Date of Birth://	Sex	First x: State or Country of Birth:			
Student's Address:		City: _	Star	te:	Zip:
Name of Mother or Legal Guardian:			Phone:		Work or Cell:
Name of Father or Legal Guardian:			Phone:		Work or Cell:
Emergency Contact:					
Zimergeney Commen					., on or com
g	T 7		G. W.	T 77	
Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)	1		iabetes		
Allergies (seasonal)			ead injury, concussions		
Asthma or breathing problems			earing problems or deafness		
Attention-Deficit/Hyperactivity Disorder	1		eart problems	1	
Behavioral problems			ead poisoning		
Developmental problems		M	uscle problems		
Bladder problem		ł	eizures	1	
Bleeding problem	1		ckle Cell Disease (not trait		
Bowel problem		Sp	eech problems		
Cerebral Palsy		Sp	oinal injury		
Cystic fibrosis		Su	ırgery		
Dental problems		Vi	ision problems		
List all prescription, over-the-counter, and	herbal me	dications your child takes regularly:			
Check here if you want to discuss confident	ial inform	nation with the school nurse or other scho	ool authority. Yes	□ No	
Please provide the following information:					
Pediatrician/primary care provider		Name	Phone		Date of Last Appointment
Specialist					
Dentist					
Case Worker (if applicable)					
Child's Health Insurance: None	FA	AMIS Plus (Medicaid) FAMIS	Private/Comm	nercial/Er	nployer sponsored
I, school setting to discuss my child's health withdraw it. You may withdraw your auth documentation of the disclosure is maintain	concerns orization or ed in your	at any time by contacting your child's so r child's health or scholastic record.	ting to this form. This authorhool. When information is	orization released	will be in place until or unless you
Signature of Parent or Legal Guardian:				Da	te:/
Signature of person completing this form:				Da	te:/

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Signature of Interpreter: __

_Date: ____

COMMONWEALTH OF VIRGINIA SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

Section I

To be completed by a physician or his designee, 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, 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.

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.

Last	Firs	t		Middle	Mo. Day Yr.
IMMUNIZATION	RE	CORD COMPLETE	E DATES (month, d	lay, year) OF VACC	INE 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 th 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 Con	firmation of Measles	Immunity:
*Rubella	1		Serological Con	firmation of Rubella I	mmunity:
*Mumps	1	2			
*Hepatitis B Vaccine (HBV) Merck adult formulation used	1	2	3		
*Varicella Vaccine	1	2	Date of Varicell Immunity:	a Disease OR Serolog	cical Confirmation of Varicella
Hepatitis A Vaccine	1	2			
Meningococcal Vaccine	1		d		
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:
Section II Conditional Enrollment and Exe	emptions
Complete the medical exemption or conditional enrollment section a	as appropriate to include signature and date.
MEDICAL EXEMPTION: As specified in the <i>Code of Virginia</i> § 22.1-271.2, C (ii), I certify that a detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (pleaning to the contraindicated because (pl	
DTP/DTaP/Tdap:[]; DT/Td:[]; OPV/IPV:[]; Hib:[]; Pneum:[]; Measles:[]; R This contraindication is permanent: [], or temporary [] and expected to preclude immunizatio Signature of Medical Provider or Health Department Official:	ons until: Date (Mo., Day, Yr.): .
RELIGIOUS EXEMPTION: The Code of Virginia allows a child an exemption from receiving im-	
student's parent/guardian submits an affidavit to the school's admitting official stating that the admit tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF I any local health department, school division superintendent's office or local department of social ser	RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at
CONDITIONAL ENROLLMENT: As specified in the <i>Code of Virginia</i> § 22.1-271.2, B, I certify required by the State Board of Health for attending school and that this child has a plan for the comp 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 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.)

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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

Weight:lbs. Height:ftin.	Referred for evaluation or treatment
Weight:lbs. Height:ftin. Body Mass Index (BMI):BP	2 3 1 2 3
EPSDT Screens Required for Head Start – include specific results and date:	Skin
EPSDT Screens Required for Head Start – include specific results and date:	Genital G
EPSDT Screens Required for Head Start – include specific results and date:	
EPSDT Screens Required for Head Start – include specific results and date:	Urinary D
EPSDT Screens Required for Head Start – include specific results and date:	
EPSDT Screens Required for Head Start – include specific results and date:	
Blood Lead: Hct/Hgh	
Diode Dated. Heritgo	
Assessed for: Assessment Method: Within normal Concern identifie	ed: Referred for Evaluation
Emotional/Social	
Emotional/Social Problem Solving Language/Communication Fine Motor Skills	
Problem Solving Language/Communication	
Fine Motor Skills	
Gross Motor Skills	
☐ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.	
Dept. ☐ 1000 2000 4000 ☐ Referred to Audiologist/ENT	☐ Unable to test – needs rescreen
B 1000 2000 4000 □ Referred to Audiologist/ENT □ Permanent Hearing Loss Previously in the property of the prop	identified: Left Right
L	_
☐ Screened by OAE (Otoacoustic Emissions): ☐ Pass ☐ Refer	
With Corrective Lenses (check if yes)	
Stereopsis	blem Identified: Referred for treatment
	Problem: Referred for prevention
NoF	Problem: Referred for prevention Referral: Already receiving dental care
☐ Pass ☐ Referred to eye doctor ☐ Unable to test – needs rescreen ☐ No F	•
☐ Pass ☐ Referred to eye doctor ☐ Unable to test – needs rescreen ☐ No F Summary of Findings (check one):	•
☐ Pass ☐ Referred to eye doctor ☐ Unable to test – needs rescreen ☐ No F Summary of Findings (check one):	Referral: Already receiving dental care
☐ Pass ☐ Referred to eye doctor ☐ Unable to test – needs rescreen ☐ No F Summary of Findings (check one):	Referral: Already receiving dental care
☐ Pass ☐ Referred to eye doctor ☐ Unable to test – needs rescreen ☐ No F Summary of Findings (check one):	Referral: Already receiving dental care
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 expla	Referral: Already receiving dental care
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 expla	Referral: Already receiving dental care
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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 explanting the section below and/or explanting the	Referral: Already receiving dental care ain here):
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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 explanting the section below and/or explanting the	ain here): □ other:
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 explanting the section below and/or explanting the	ain here): □ other:
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 explanting the section below and/or explanting the	ain here): □ other:
Pass	ain here): other: /or available at school

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