

**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: \_\_\_\_\_

Student's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_ State or Country of Birth: \_\_\_\_\_ Middle Main Language Spoken: \_\_\_\_\_

Student's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head injury, concussions		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Lead poisoning		
Developmental problems			Muscle problems		
Bladder problem			Seizures		
Bleeding problem			Sickle Cell Disease (not trait)		
Bowel problem			Speech problems		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.): \_\_\_\_\_

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 Plus (Medicaid) \_\_\_\_ FAMIS \_\_\_\_ Private/Commercial/Employer sponsored

**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 person completing this form: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Interpreter: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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**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.

Student's Name: \_\_\_\_\_ Date of Birth: | | | |  
*Last* *First* *Middle* *Mo.* *Day* *Yr.*

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
	1	2	3	4	5
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)					
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)					
*Tdap booster (6 <sup>th</sup> grade entry)					
*Polio (IPV, OPV)					
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age					
*Pneumococcal (PCV conjugate) *only for children <60 months of age					
Measles, Mumps, Rubella (MMR vaccine)					
*Measles (Rubeola)			Serological Confirmation of Measles Immunity:		
*Rubella			Serological Confirmation of Rubella Immunity:		
*Mumps					
*Hepatitis B Vaccine (HBV) <input type="checkbox"/> Merck adult formulation used					
*Varicella Vaccine			Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine					
Meningococcal Vaccine					
Human Papillomavirus Vaccine					
Other					
Other					

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.): \_\_\_\_/\_\_\_\_/\_\_\_\_



**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](http://www.vahealth.org/schoolhealth).

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  M  F

<b>Health Assessment</b>	Date of Assessment: ____/____/____ Weight: _____ lbs. Height: _____ ft. ____ in. Body Mass Index (BMI): _____ BP _____ <input type="checkbox"/> Age / gender appropriate history completed <input type="checkbox"/> Anticipatory guidance provided	<b>Physical Examination</b> 1 = Within normal    2 = Abnormal finding    3 = Referred for evaluation or treatment										
		1	2	3	1	2	3	1	2	3		
	HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TB Screening: <input type="checkbox"/> No risk for TB infection identified <input type="checkbox"/> No symptoms compatible with active TB disease <input type="checkbox"/> Risk for TB infection or symptoms identified Test for TB Infection: TST IGRA Date: _____ TST Reading _____ mm    TST/IGRA Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative CXR required if positive test for TB infection or TB symptoms.    CXR Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal												
EPSDT Screens <b>Required</b> for Head Start -- include specific results and date: Blood Lead: _____ Hct/Hgb _____												

<b>Developmental Screen</b>	Assessed for:	Assessment Method:	Within normal	Concern identified:	Referred for Evaluation	
	Emotional/Social					
	Problem Solving					
	Language/Communication					
	Fine Motor Skills					
	Gross Motor Skills					

<b>Hearing Screen</b>	<input type="checkbox"/> Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.				<input type="checkbox"/> Referred to Audiologist/ENT <input type="checkbox"/> Unable to test -- needs rescreen <input type="checkbox"/> Permanent Hearing Loss Previously identified: ___Left ___Right <input type="checkbox"/> Hearing aid or other assistive device
		1000	2000	4000	
	R				
	L				
<input type="checkbox"/> Screened by OAE (Otoacoustic Emissions): <input type="checkbox"/> Pass <input type="checkbox"/> Refer					

<b>Vision Screen</b>	<input type="checkbox"/> With Corrective Lenses (check if yes)					<b>Dental Screen</b>	<input type="checkbox"/> Problem Identified: Referred for treatment <input type="checkbox"/> No Problem: Referred for prevention <input type="checkbox"/> No Referral: Already receiving dental care
	Stereopsis		<input type="checkbox"/> Pass <input type="checkbox"/> Fail		<input type="checkbox"/> Not tested		
	Distance	Both	R	L	Test used:		
		20/	20/	20/			
<input type="checkbox"/> Pass <input type="checkbox"/> Referred to eye doctor <input type="checkbox"/> Unable to test -- needs rescreen							

<b>Recommendations to (Pre) School, Child Care, or Early Intervention Personnel</b>	Summary of Findings (check one): <input type="checkbox"/> Well child; no conditions identified of concern to school program activities <input type="checkbox"/> Conditions identified that are important to schooling or physical activity (complete sections below and/or explain here): _____	
	___ Allergy <input type="checkbox"/> food: _____ <input type="checkbox"/> insect: _____ <input type="checkbox"/> medicine: _____ <input type="checkbox"/> other: _____ Type of allergic reaction: <input type="checkbox"/> anaphylaxis <input type="checkbox"/> local reaction    Response required: <input type="checkbox"/> none <input type="checkbox"/> epinephrine auto-injector <input type="checkbox"/> other: _____	
	___ Individualized Health Care Plan needed (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)	
	___ Restricted Activity Specify: _____	
	___ Developmental Evaluation <input type="checkbox"/> Has IEP <input type="checkbox"/> Further evaluation needed for: _____	
	___ Medication. Child takes medicine for specific health condition(s). <input type="checkbox"/> Medication must be given and/or available at school.	
	___ Special Diet Specify: _____	
	___ Special Needs Specify: _____	
Other Comments: _____		

<b>Health Care Professional's Certification</b> (Write legibly or stamp) <input type="checkbox"/> 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 Name: _____	Address: _____	
Phone: _____	Fax: _____	Email: _____