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 Vir*ginia § 22.1-270) requires that your child is completely immunized and receives a comprehensive physical examination before entering public kindergarten. The parent or guardian completes this page of the form. The Medical Provider completes the second and third pages of the form. This form must be completed within one year before your child's first day in kindergarten or elementary school.

Name of School: _____ Grade: _____

Student's Name: _____
Last *First* *Middle*

Student's Date of Birth: |_____|_____|_____| Sex: |____| State or Country of Birth: _____
Mo. *Day* *Yr.*

Student's Social Security #: |___|___|___| - |___|___| - |___|___|___|___| or I.D. #: _____

Student's Address: _____City: _____ State: _____ Zip: _____

Name of Mother or Legal Guardian: _____

Home Phone: |___|___|___| - |___|___|___| - |___|___|___|___| Work Phone: |___|___|___| - |___|___|___| - |___|___|___|___|
Area Code *Area Code*

Name of Father or Legal Guardian: _____

Home Phone: |___|___|___| - |___|___|___| - |___|___|___|___| Work Phone: |___|___|___| - |___|___|___| - |___|___|___|___|
Area Code *Area Code*

In case of emergency—if parent or guardian cannot be contacted—contact the following:

1. Name: _____ Complete Phone Number: |___|___|___| - |___|___|___| - |___|___|___|___|
2. Name: _____ Complete Phone Number: |___|___|___| - |___|___|___| - |___|___|___|___|

Assessment of Student's Health

To the best of your knowledge, has your child had any problem with the following? Please check yes or no.

Condition	Yes	No	Comments if "Yes"
Allergies (food, insects, drugs, latex)			
Allergies (seasonal)			
Asthma or breathing problems			
Attention-Deficit/Hyperactivity Disorder			
Behavioral problems			
Developmental problems			
Bladder problem			
Bleeding problems			
Bowel problem			
Cerebral Palsy			
Cystic Fibrosis			
Dental problems			
Diabetes			
Head or spinal Injury			
Hearing problems or deafness			
Heart problems			
Hospitalizations (when, why)			
Lead poisoning			
Muscular problems			
Seizures			
Sickle Cell Disease (not trait)			
Speech problems			
Surgery			
Vision problems			
Other:			

List all prescription and over-the-counter medications your child takes regularly: _____

_____

Describe any other important health-related information about your child (i.e., feeding tube, oxygen support, hearing aid, etc.): _____

_____

_____

Name of your child's pediatrician or primary care provider: _____

Names of medical specialists or special clinics caring for your child: _____

_____

Has your child ever seen a dentist? Yes: |___|, No: |___|. If yes, date of last appointment: _____

Check here if you want to discuss confidential information with the school nurse or other school authority: Yes |___|, No |___|.

Check here if you give permission for the school nurse or other school authority to contact the examining physician to discuss any information contained on this form: Yes |___|, No |___|.

Signature of Parent or Legal Guardian: _____ **Date (*Mo., Day, Yr.*):** |___|___|___|

Signature of Interpreter: _____ **Date (*Mo., Day, Yr.*):** |___|___|___|

Part II - COMPREHENSIVE PHYSICAL EXAMINATION REPORT

Part II must be completed by a qualified licensed physician. nurse practitioner, or physician assistant. The exam must be done within one year before enrollment in kindergarten or elementary school (Ref. *Code of Virginia* § 22.1-270).

Student's Name: _____
Last *First* *Middle*

Date of Birth: |_____|_____|_____| Sex: _____ (M/F) Height: _____ Weight: _____ BMI Percentile _____ Blood Pressure: _____
Mo. *Day* *Yr.*

Required Screening Tests (see Part IV)	Explanation	Result		
Anemia Screen (questions on back of form)	If positive, do hemoglobin or hematocrit	Neg:	Hgb or Hct:	
Urine Screen	Dipstick urine for glucose, protein, & other	Glucose:	Protein:	Other:
Vision Screen	Distance visual acuity without correction	Right: 20/	Left: 20/	Both: 20/
	Distance visual acuity with correction	Right: 20/	Left: 20/	Both: 20/
Stereopsis (Ocular Alignment)	Description on back of form	Pass:	Fail:	
Hearing Screen	Must be done with pure tone audiometry at 20 dbl	Right:	Left:	
Lead level (criteria on back of form)	Blood lead level	Date:	Result:	
Optional Screening Tests (see Part IV)				
Tuberculin skin test (criteria on back of form)	May be required in high-risk groups	Pos:	Neg:	Date:

Vision Screening:
Child to be rescreened? Yes |___|, No |___| Child to be referrred? Yes |___|, No |___|

Hearing:
Child to be rescreened? Yes |___|, No |___| Child to be referred? Yes |___|, No |___|

Systems Examination		Normal	Abnormal	Not Examined	Comments About Findings
General Appearance					
Skin					
Head					
Eyes:	External				
	Fundi				
Ears:	External and Canal				
	Tympanic Membrane				
Nose					
Throat					
Mouth / Teeth					
Neck					
Chest					
Heart					
Lungs					
Abdomen					
Genitalia (Tanner Stage)					
Bones, Joints, Muscles					
Neurological					
Posture / Range of Motion					
Other:					

		Comments
Estimated Developmental Level:	Cognitive Development	
	Speech / Language Development	
	Social / Emotional Development	
	Health Behaviors / Health Habits	

Assessment including medical diagnoses and potentially disabling conditions that might require (1) educational evaluation, (2) environmental adjustment, or (3) activity limitation: _____

_____

_____

_____

Recommendations: _____

_____

_____

Referrals made, if any: _____

_____

Medical Provider's Name (print):_____ Phone No. |___|___|___| - |___|___|___|___| - |___|___|___|___|

Medical Provider's Address: _____ City: _____ State: _____ Zip: |___|___|___|___|___|

Signature of Medical Provider: _____ **Date (*Mo., Day, Yr.*):**|___|___|___|

PART III - CERTIFICATION OF IMMUNIZATION

Part III to be completed by a physician, nurse practitioner, or health department official.

Student's Name: _____ Date of Birth: |____|____|____|
Last *First* *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**
Poliomyelitis (IPV, OPV)	**1**	**2**	**3**	**4**	
Haemophilus influenzae Type b (Hib conjugate)	**1**	**2**	**3**	**4**	
Pneumococcal (PCV conjugate)	**1**	**2**	**3**	**4**	
Measles, Mumps, Rubella (MMR vaccine)	**1**	**2**			
Measles (Rubeola)	**1**	**2**	Serological Confirmation of Measles Immunity :		
Rubella	**1**	**2**	Serological Confirmation of Rubella Immunity :		
Mumps	**1**	**2**			
Hepatitis B Vaccine (HBV)	**1**	**2**	**3**		
Varicella Vaccine	**1**		Date of Varicella Disease:		
Other	**1**	**2**	**3**	**4**	**5**

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:[___]; DT/Td:[___]; OPV/IPV:[___]; Hib:[___]; Pneum:[___]; Measles:[___]; Rubella:[___]; Mumps:[___]; HBV:[___]; Varicella:[___]

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).

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 days (conditional enrollment). Next immunization due on _____.

Signature of Medical Provider or Health Department Official: _____ **Date (*Mo., Day, Yr.*):**|___|___|___|

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, daycare or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Minimum requirements are listed on the last page of this form).

Signature of Medical Provider or Health Department Official: _____ **Date (*Mo., Day, Yr.*):**|___|___|___|

Anemia Screen (Required) *

Screen for Anemia (hemoglobin or hematocrit) if any of the following are positive:

- ❑ Family has low income (Child eligible for Medicaid)
- ❑ Child eligible for WIC
- ❑ Migrant or recently arrived refugee
- ❑ Consumes a diet low in iron
- ❑ Child has limited access to food
- ❑ Child with special health care needs
- ❑ Child with history of iron-deficiency anemia
- ❑ Child takes medication that inhibits iron absorption

Urine Screen (Required) *

- ❑ Dipstick test for glucose and protein

Vision Screen (Required) *

- ❑ Test distance visual acuity in children over 3 years of age with Snellen letters, Snellen numbers, Tumbling E, HOTV, or Picture tests (Allen figures or LH symbol test)
- ❑ Distance testing at 10 feet is recommended
- ❑ Refer if worse than 20/40 with either eye (if child 3-5 years old) or 20/30 (if child 6 years old or older)
- ❑ Refer if two-line difference between eyes even if within passing range (i.e., 20/25 & 20/40 or 20/20 & 20/30)

Ocular Alignment *

Test ocular alignment in children 3 years of age and older using the unilateral cover test, the Random-dot-E test, or similar test. Refer if there is any eye movement with the unilateral cover test or less than 4 of 6 correct with the Random-dot-E test.

Hearing Screen (Required) *

- ❑ Must use pure tone audiometer (if at least 4 years old) - screen at 1000, 2000, & 4000 Hz tones at 20 dB HL in each ear.
- ❑ Reposition earphones and rescreen if the child does not pass at this dB level.
- ❑ Refer to audiologist if child does not pass rescreen at 20dB level.

Lead Screen (Required)

Test children 6 and under who were not previously tested if any of the following are true:

- ❑ Child receives services from Medicaid or WIC
- ❑ Child resides in high-risk zip code area (consult www.vahealth.org/leadsafe for list of high-risk zip codes)
- ❑ Child lives in or regularly visits a house or child-care facility built before 1950
- ❑ Child lives in or regularly visits a house or child-care facility built before 1978 that is being or was renovated within the past 6 months
- ❑ Child lives in or regularly visits a house or other structure in which one or more persons have elevated blood lead levels
- ❑ Child lives with an adult whose job or hobby involves exposure to lead
- ❑ Child lives near an active lead smelter, battery recycling plant, or other industry likely to release lead
- ❑ Child's parent or guardian requests the child's blood be tested due to any suspected exposure
- ❑ Health care provider recommends the child's blood be tested due to any suspected exposure

Tuberculosis Infection Risk (Recommended)

Consider administering a Mantoux TB skin test if the child has one or more of the following risk factors:

- ❑ Exposure to tuberculosis or to high risk adults
- ❑ TB-like symptoms
- ❑ Lived in high prevalence country or extensive travel in areas with high prevalence
- ❑ Homelessness or resident in congregate living
- ❑ Medically underserved
- ❑ HIV infection or receiving immunosuppressive therapy
- ❑ Other medical risk factors (i.e., malignancy, diabetes)

Local school systems may have specific testing requirements and policies. Please consult with your local health department.

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 4th birthday unless received 6 doses before 4th birthday.
- ❑ 3 Polio Vaccine – at least one dose after 4th birthday unless received 4 doses of all OPV or all IPV prior to 4th birthday.
- ❑ Hib – 2-3 doses in infancy; 1 booster between 12-15 months; 1 dose between 15-60 months if unvaccinated.
- ❑ 3 Hep B doses – required for children born on or after January 1, 1994 and for students enrolling in 6th grade on or after July 1, 2001 if unvaccinated.
- ❑ 2 Measles – 1st dose on/after 12 months (365 days) of age; 2nd dose prior to entering kindergarten.
- ❑ 1 Mumps - on/after 12 months (365 days) of age.
- ❑ 1 Rubella - on/after 12 months (365 days) of age.
- ❑ 1 Varicella – to susceptible children born on/after January 1, 1997; dose on/after 12 months (365 days) of age.

* Source: *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents*, 2000