

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Health Information Form / Comprehensive Physical Examination Report / Certification of Immunization

Part I - HEALTH INFORMATION FORM

Part I to be completed by parents or guardians of entering students. Ref. Code of Virginia § 22.1-270, 1.

Student's Name: _____
Last First Middle

Student's Date of Birth: Mo. | Day | Yr. | Sex: | | Number of Children in Family: | | State or Country of Birth: _____

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

Student's Address: _____ City: _____ State: _____ Zip: | | | | |

Name of School: _____ Grade: _____

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: | | | | | - | | | | | - | | | | |

Birth History (weight, premature, and any other problems at birth): _____

ALLERGIES (food, medicine, insect bites, and any other allergies): _____

Equipment Used and Specialized Health Care Needed <small>(Check all that apply and explain below. *)</small>		Chronic, Recurring, and Special Health Conditions <small>(Check all that apply and explain below. *)</small>	
Equipment Used by Child:	Catheterization		Arthritis (rheumatoid)
<input type="checkbox"/> Glasses / Contact Lens	<input type="checkbox"/> Clean Intermittent Catheterization	<input type="checkbox"/>	Asthma
<input type="checkbox"/> Hearing Aid	<input type="checkbox"/> External Catheter	<input type="checkbox"/>	Attention-Deficit/Hyperactivity Disorder
<input type="checkbox"/> Helmet	<input type="checkbox"/> Other:	<input type="checkbox"/>	Behavioral or Developmental Problems
<input type="checkbox"/> Wheelchair / Walker	Medical Support Systems	<input type="checkbox"/>	Cerebral Palsy
<input type="checkbox"/> Other:	<input type="checkbox"/> Hickman / Broviac / IVAC/ IMED	<input type="checkbox"/>	Cystic Fibrosis
	<input type="checkbox"/> Mechanical Ventilator	<input type="checkbox"/>	Dental Problems
	<input type="checkbox"/> Oxygen	<input type="checkbox"/>	Diabetes
Specialized Health Care Needed:	<input type="checkbox"/> Ventricular Peritoneal Shunt	<input type="checkbox"/>	Encopresis (involuntary discharge of stool)
Activities of Daily Living	<input type="checkbox"/> Other:	<input type="checkbox"/>	Enuresis (involuntary discharge of urine)
<input type="checkbox"/> Bowel / Bladder Training	Stomies	<input type="checkbox"/>	Head or Spinal Injury
<input type="checkbox"/> Diapering / Toileting	<input type="checkbox"/> Ostomy Care	<input type="checkbox"/>	Hearing Impairment
<input type="checkbox"/> Lifting / Positioning	<input type="checkbox"/> Other:	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/> Other:	Respiratory Assistance	<input type="checkbox"/>	Kidney Disease
Feeding	<input type="checkbox"/> Percussion	<input type="checkbox"/>	Muscular Dystrophy
<input type="checkbox"/> Gastrostomy Feeding	<input type="checkbox"/> Postural Drainage	<input type="checkbox"/>	Seizures
<input type="checkbox"/> Jejunostomy Tube Feeding	<input type="checkbox"/> Suctioning	<input type="checkbox"/>	Sickle Cell Disease (not trait)
<input type="checkbox"/> Naso-Gastric Feeding	<input type="checkbox"/> Other:	<input type="checkbox"/>	Spina Bifida
<input type="checkbox"/> Oral Feeding	Specimen Collecting / Testing	<input type="checkbox"/>	Visual Impairment
<input type="checkbox"/> Total Parenteral Feeding	<input type="checkbox"/> Blood Glucose	<input type="checkbox"/>	Other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/>	
*Explanation: _____			

Describe any family history of chronic illnesses or genetic concerns (please list family member in relation to child [e.g., mother] and name of condition [e.g., anemia, arthritis, cancer, diabetes, heart disease, high blood pressure, kidney disease, mental illness, stroke, tuberculosis]): _____

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

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

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

Describe your child's operations and hospitalizations, if any (reason and date): _____

Describe any other important health-related information about your child: _____

Check here if you want to discuss confidential information with 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.):** | | | | |

Part II - COMPREHENSIVE PHYSICAL EXAMINATION REPORT

Part II to be completed by a qualified licensed physician. All components, unless otherwise indicated, are to be performed no earlier than twelve months prior to the date child enters kindergarten or elementary school. Ref. Code of Virginia § 22.1-270, A-H.

Student's Name: _____
Last First Middle

Date of Birth: |__|_|_|_| Height: _____ Weight: _____ Head Circumference: _____ Blood Pressure: _____
Mo. Day Yr.

Hemoglobin: _____ gms or Hematocrit: _____%. Urine: Albumin _____, Sugar _____, Other _____

Results of Mantoux tuberculin skin test, optional (may be required in high-risk groups): _____mm. Date of test: |__|_|_|_|
Mo. Day Yr.

If performed, date of most recent blood lead level: |__|_|_|_| Results: _____ µg/dL
Mo. Day Yr.

Vision Screening

Distance visual acuity screening results, without correction: Right Eye 20/____ Left Eye 20/____ Both Eyes 20/____

Distance visual acuity screening results, with correction: Right Eye 20/____ Left Eye 20/____ Both Eyes 20/____

If performed, stereopsis screening results: Pass _____ Fail _____

Child to be rescreened? Yes , No Child to be referred? Yes , No

Hearing

Hearing screening results: Right Ear _____ Left Ear _____ Equipment used: _____

If performed, hearing evaluation results: Right Ear _____ Left Ear _____

If indicated, Tympanogram: Normal _____ Abnormal _____

Child to be rescreened? Yes , No Child to be referred? Yes , No

Systems Examination	Examined	Not Examined	Comments About Findings
General Appearance			
Nutritional Status			
Posture / Motor Behavior			
Skin			
Head			
Eyes:	External		
	Fundi		
Ears:	External and Canal		
	Tympanic Membrane		
Nose			
Throat			
Mouth / Teeth			
Neck			
Heart			
Lungs			
Abdomen			
Genitalia (Tanner Stage)			
Bones, Joints, Muscles			
Neurological			
Estimated Developmental Level:	Cognitive Development		
	Speech / Language Development		
	Social / Emotional Development		
	Health Behaviors / Health Habits		
Other:			

Summary of abnormal physical findings, if any: _____

Medical diagnoses: _____

Describe specifically what, if any, conditions are found that would identify the child as having a disability, including conditions that might require (1) educational evaluation, (2) environmental adjustment, or (3) activity limitation: _____

Assessment: _____

Recommendations and referrals made, if any: _____

Physician's Address: _____ City: _____ State: _____ Zip: |__|_|_|_|

Physician's Name (print): _____ Phone No. |__|_|_|_| - |__|_|_|_| - |__|_|_|_|

Signature of Physician: _____ **Date (Mo., Day, Yr.):** |__|_|_|_|

PART III - CERTIFICATION OF IMMUNIZATION

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

Student's Name: _____ Date of Birth: _____

Last
First
Middle
Mo. Day Yr.

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

Name of Parent/Guardian: _____

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)					
Poliomyelitis (OPV or IPV)					
Haemophilus influenzae Type b (Hib Conjugate Vaccine)					
Measles (Rubeola)			Serological Confirmation of Measles Immunity :		
Rubella			Serological Confirmation of Rubella Immunity :		
Mumps			Other (List type and date received):		
Measles, Mumps, Rubella (MMR vaccine)					
Hepatitis B Vaccine (HBV)				Other:	
Varicella Vaccine			Other:		Other:
Rotavirus Vaccine				Other:	

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:[]; HBV:[]; Measles:[]; Mumps:[]; Rubella:[]; Varicella:[]

This contraindication is permanent: [] or temporary [] and expected to preclude immunizations until: Date (Mo., Day, Yr.): [] [] [].

Signature of Physician 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 student has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this student has a plan for the completion of his/her requirements within the next 90 days (conditional enrollment):

Signature of Physician or Health Department Official: _____ **Date (Mo., Day, Yr.):** [] [] []

I certify that this student is **ADEQUATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (For information or questions on immunization regulations, please call your local health department or the Virginia Department of Health, Division of Immunization, at 1-800-568-1929):

Signature of Physician or Health Department Official: _____ **Date (Mo., Day, Yr.):** [] [] []