

**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: _____ 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:** ____/____/____

**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.

Student's Name: _____ Date of Birth:

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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 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 <60 months of age	1	2	3	4	
Measles, Mumps, Rubella (MMR vaccine)	1	2			
*Measles (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
*Rubella	1		Serological Confirmation of Rubella Immunity:		
*Mumps	1	2			
*Hepatitis B Vaccine (HBV) <input type="checkbox"/> Merck adult formulation used	1	2	3		
*Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
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 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.

Student's Name: _____ Date of Birth: ____/____/____ Sex: M F

Health Assessment	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	Physical Examination 1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment <table style="width:100%; border:none;"> <tr> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> </tr> <tr> <td>HEENT</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Neurological</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Skin</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Lungs</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Abdomen</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Genital</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Heart</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Extremities</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Urinary</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		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"/>
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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 <u>Required</u> for Head Start – include specific results and date: Blood Lead: _____ Hct/Hgb _____																																																		

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

Hearing Screen	<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					

Vision Screen	<input type="checkbox"/> With Corrective Lenses (check if yes)			
	Stereopsis	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Not tested	
	Distance	Both	R	L
		20/	20/	20/
<input type="checkbox"/> Pass <input type="checkbox"/> Referred to eye doctor <input type="checkbox"/> Unable to test – needs rescreen				

Dental Screen	<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
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Recommendations to (Pre) School, Child Care, or Early Intervention Personnel	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: _____
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Health Care Professional's Certification (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: _____

AUTHORIZATION TO APPLY A NON-PRESCRIPTION TOPICAL SKIN PRODUCT
(Such as Sunscreen, Diaper Ointment and Lotion, Oral Teething Medicine and Insect Repellant
as required by 22 VAC 40-111-750 of the Standards for Licensed Family Day Homes)

_____ has my permission to apply the following
(Name of Provider) non-prescription topical skin product to my child,

(Name of Child)

Product Name: _____

Known Adverse Reactions (if any): _____

- The product must be in the original container and, if provided by the parent, labeled with the child's name
- Manufacturer's instructions for application must be followed
- Parents must be informed immediately of any adverse reaction
- The product must not be used beyond the expiration date of the product
- Sunscreen must have a minimum sunburn protection factor (SPF) of 15

This authorization is effective until: _____ (the effective period must not exceed one calendar year from the date of the parent's signature below).

Parent's Signature: _____ Date: _____

CHILD'S RECORD

- o INDICATE "N/A" IF THE INFORMATION IS NOT APPLICABLE.
- o THE COMPLETED FORM MUST BE KEPT IN THE CHILD'S RECORD AND THE FIRST PAGE UPDATED ANNUALLY.
- o THE INFORMATION IN THIS FORM IS REQUIRED BY FAMILY DAY HOME STANDARD 22 VAC 40-111-60.

Child's Full Name	Nickname	Sex	Birth date
Street Address	City	State	Zip
			First Day of Attendance
			Last Day of Attendance
If Child Attends School, Give Name of School			Grade
EMERGENCY INFORMATION			
Allergies and intolerance to food, medications, or other substances. Actions to take in emergency situation.			
Chronic Physical Problems/Diseases; Pertinent Development Information; Special Accommodations Needed; Special Instructions to Provider			
Father's Full Name	Phone	Employer	
Father's Employer's Address (Street Address)			Father's Work Phone
Father's Home Address (Street Address) (enter "Same" if address is the same as the child's)			
Mother's Full Name	Phone	Employer	
Mother's Employer's Address (Street Address)			Mother's Work Phone
Mother's Home Address (Street Address) (enter "Same" if address is the same as the child's)			
Child's Physician	Office Address (Street Address)		Phone
	City	State	Zip
Name of Child's Medical Insurance			Policy Number
Name of Emergency Contact if Parent(s) Cannot Be Reached	Street Address		Phone
	City	State	Zip
Name of Emergency Contact if Parent(s) Cannot Be Reached	Street Address		Phone
	City	State	Zip
Person(s) Authorized to Pick Up Child (Appropriate custodial paperwork (custody order or other court order) shall be attached if a parent is not allowed to pick up the child)			
Parent Signature _____			Date _____ (Valid for One Year)
1st yr. review _____			
	Parent Signature	_____	Date _____
2nd yr. review _____			
	Parent Signature	_____	Date _____
3rd yr. review _____			
	Parent Signature	_____	Date _____

CHILD'S RECORD

PROOF OF AGE AND IDENTITY (must be obtained from parent within 7 business days of child's first day of attendance)			
Names & Locations (City and State) of Previous Child Day Care Programs & Schools Attended			
Place of Birth	Birth Date	Birth Certificate Number	Date Issued
Proof of Age Other Than Birth Certificate*		Date Documentation Viewed	Person Viewing Documentation
NOTIFICATION OF LOCAL LAW ENFORCEMENT AGENCY (if parent does not provide proof of child's age and identity within 7 business days of child's first day of attendance)			
Date of Notification		Name of Agency Notified	Name of Individual Notified

*Proof of age and identity may be verified by viewing one of the following: certified birth certificate; birth registration card; notification of birth, i.e., hospital, physician, or midwife record; passport; copy of the placement agreement or other proof of the child's identity from a child placing agency; original or copy of a record or report card from a public school in Virginia; signed statement on letterhead stationery from a public school principal or other designated official that assures the child is or was enrolled in the school; or child identification card issued by the Virginia Department of Motor Vehicles.

EMERGENCY MEDICAL AUTHORIZATION	
<p>I authorize _____ to obtain immediate care and consent to emergency medical procedures upon, the hospitalization of, the performance of necessary diagnostic tests upon, the use of surgery on, and/or the administration of drugs to _____ if an emergency occurs and I cannot be located immediately.</p> <p style="text-align: center; margin-left: 100px;">Name of Licensed Provider Name of Child</p> <p>It is also understood that this agreement covers only those situations which are true emergencies and only when I cannot be reached. Otherwise I expect to be notified immediately.</p> <p>_____</p> <p style="display: flex; justify-content: space-between;">Signature of ParentDate</p> <p>The child's Emergency Information and the Emergency Medical Authorization must be made available to a physician, hospital, or emergency responders in the event of a child's illness or injury.</p>	

ADDITIONAL DOCUMENTS REQUIRED FOR CHILD'S RECORD

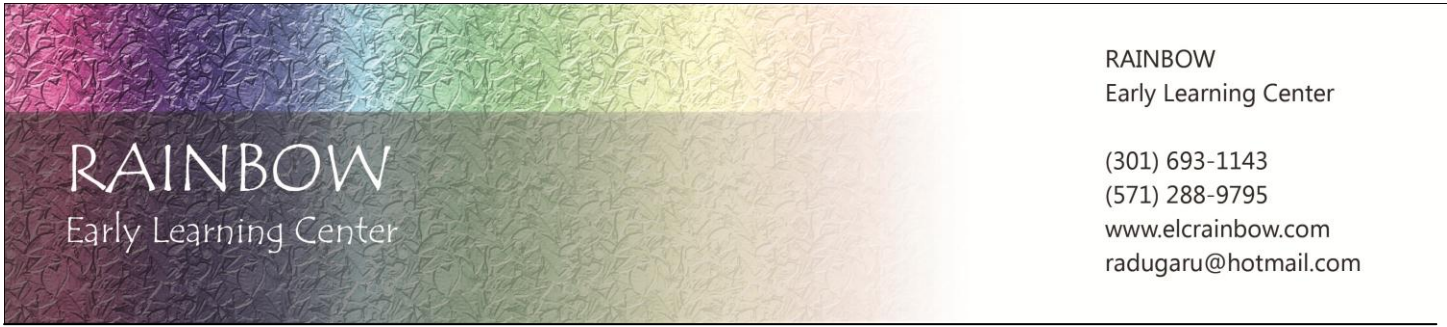
- ___ Immunization and Physical Examination Record Form MCH213 F (signed by physician, physician's designee, or health official)
- ___ Information for Parents (signed by parent)
- ___ Policy for the Administration of Medications (signed by parent)
- ___ Liability Insurance Declaration (signed by parent)
- ___ Provisions of the Home's Emergency Preparedness and Response Plan (signed by parent)

As Applicable:

- ___ General Permission for Regularly Scheduled Trips (signed by parent)
- ___ Special Field Trip Permission (signed by parent)
- ___ Medication Consent (signed by parent) ***Valid for 10 days unless also signed by physician**
- ___ Permission to Participate in Swimming or Wading Activities (signed by parent) ***Valid for one year**
- ___ Injury Record(s)

If Child with Special Needs is in Care:

- ___ Staffing Recommendation for a Child with Special Needs (signed by parent, provider, and Licensing representative)
- ___ Individual Health Care/Special Needs (signed by licensed health care professional)



ABOUT MY CHILD

*Thank you for taking the time to complete this information about your child.
Knowing a little more about your child's likes and dislikes will help our teachers and support team make his or her childhood experience special.*

Child's Name: _____ Date Of Birth: ____/____/____

My Child's Favorites:

Food(s): _____

Color(s): _____

Activities: _____

Cartoon/Literary Character(s): _____

Book: _____

Toy/Object: _____

Other Important Information

My child like _____

My child dislike _____

When my child is tired, he/she sometimes wants _____

My child may need help with the following: _____

Special requests/needs: _____

Anything you would like us to know about your child: _____
