

**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: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last First Middle  
 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: |\_\_| |\_\_| |\_\_|  
*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 |
| *Tdap booster (6 <sup>th</sup> grade entry)  | 1   |   |  |   |   |
| *Poliomyelitis (IPV, OPV)  | 1   | 2 | 3  | 4 |   |
| *Haemophilus influenzae Type b (Hib conjugate)<br>*only for children <60 months of age | 1   | 2 | 3  | 4 |   |
| *Pneumococcal (PCV conjugate)<br>*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)<br><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.):** \_\_\_/\_\_\_/\_\_\_

**Section II**  
**Conditional Enrollment and Exemptions**

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date.

**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/Tdap:[\_\_]; 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).

**CONDITIONAL ENROLLMENT:** As specified in the *Code of Virginia* § 22.1-271.2, B, 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 calendar days. Next 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.)**

**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>  | <b>Date of Assessment:</b> ____/____/____<br>Weight: _____lbs. Height: _____ft. ____in.<br>Body Mass Index (BMI): _____ BP _____<br><input type="checkbox"/> Age / gender appropriate history completed<br><input type="checkbox"/> Anticipatory guidance provided | <b>Physical Examination</b><br>1 = Within normal    2 = Abnormal finding    3 = Referred for evaluation or treatment<br><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"/> |
|   |  | 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"/> |                          |   |   |       |                          |                          |                          |              |                          |                          |                          |      |                          |                          |                          |       |                          |                          |                          |         |                          |                          |                          |         |                          |                          |                          |       |                          |                          |                          |             |                          |                          |                          |         |                          |                          |                          |
| <b>TB Screening:</b> <input type="checkbox"/> No risk for TB infection identified <input type="checkbox"/> No symptoms compatible with active TB disease<br><input type="checkbox"/> Risk for TB infection or symptoms identified   |  |  |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |   |   |       |                          |                          |                          |              |                          |                          |                          |      |                          |                          |                          |       |                          |                          |                          |         |                          |                          |                          |         |                          |                          |                          |       |                          |                          |                          |             |                          |                          |                          |         |                          |                          |                          |
| <b>Test for TB Infection:</b> TST IGRA Date: _____ TST Reading _____mm    TST/IGRA Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative<br><b>CXR required if positive test for TB infection or TB symptoms.</b> CXR Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |  |  |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |   |   |       |                          |                          |                          |              |                          |                          |                          |      |                          |                          |                          |       |                          |                          |                          |         |                          |                          |                          |         |                          |                          |                          |       |                          |                          |                          |             |                          |                          |                          |         |                          |                          |                          |
| <b>EPSDT Screens <u>Required</u> for Head Start – include specific results and date:</b><br>Blood Lead: _____ Hct/Hgb _____   |  |  |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |   |   |       |                          |                          |                          |              |                          |                          |                          |      |                          |                          |                          |       |                          |                          |                          |         |                          |                          |                          |         |                          |                          |                          |       |                          |                          |                          |             |                          |                          |                          |         |                          |                          |                          |

|                             | Assessed for:          | Assessment Method: | Within normal | Concern identified: | Referred for Evaluation |
|-----------------------------|------------------------|--------------------|---------------|---------------------|-------------------------|
| <b>Developmental Screen</b> | 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<br><input type="checkbox"/> Permanent Hearing Loss Previously identified: ___Left ___Right<br><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)         |      |                                     |     |            |
|  | 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>Dental Screen</b> | <input type="checkbox"/> Problem Identified: Referred for treatment<br><input type="checkbox"/> No Problem: Referred for prevention<br><input type="checkbox"/> No Referral: Already receiving dental care |
|----------------------|--|

|   |  |  |
|---|--|--|
| <b>Recommendations to (Pre) School, Child Care, or Early Intervention Personnel</b> | <b>Summary of Findings (check one):</b><br><input type="checkbox"/> Well child; no conditions identified of concern to school program activities<br><input type="checkbox"/> Conditions identified that are important to schooling or physical activity (complete sections below and/or explain here): _____<br>_____<br>_____<br>___ Allergy <input type="checkbox"/> food: _____ <input type="checkbox"/> insect: _____ <input type="checkbox"/> medicine: _____ <input type="checkbox"/> other: _____<br>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: _____<br>___ <b>Individualized Health Care Plan needed</b> (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)<br>___ <b>Restricted Activity</b> Specify: _____<br>___ <b>Developmental Evaluation</b> <input type="checkbox"/> Has IEP <input type="checkbox"/> Further evaluation needed for: _____<br>___ <b>Medication.</b> Child takes medicine for specific health condition(s). <input type="checkbox"/> Medication must be given and/or available at school.<br>___ <b>Special Diet</b> Specify: _____<br>___ <b>Special Needs</b> Specify: _____<br>___ <b>Other Comments:</b> _____ |  |
|---|--|--|

|  |                            |                      |
|--|----------------------------|----------------------|
| <b>Health Care Professional's Certification</b> (Write legibly or stamp) <input type="checkbox"/> <b>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).</b> |                            |                      |
| Name: _____  | Signature: _____           | Date: ____/____/____ |
| Practice/Clinic Name: _____  | Address: _____             |                      |
| Phone: _____ - _____ - _____   | Fax: _____ - _____ - _____ | Email: _____         |