

**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 Mother or Legal Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work or Cell: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Name of Father or Legal Guardian: \_\_\_\_\_ 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 or spinal injury           |     |          |
| Asthma or breathing problems             |     |          | Hearing problems or deafness    |     |          |
| Attention-Deficit/Hyperactivity Disorder |     |          | Heart problems                  |     |          |
| Behavioral problems                      |     |          | Hospitalizations                |     |          |
| Developmental problems                   |     |          | Lead poisoning                  |     |          |
| Bladder problem                          |     |          | Muscle problems                 |     |          |
| Bleeding problem                         |     |          | Seizures                        |     |          |
| Bowel problem                            |     |          | Sickle Cell Disease (not trait) |     |          |
| Cerebral Palsy                           |     |          | Speech problems                 |     |          |
| Cystic fibrosis                          |     |          | Surgery                         |     |          |
| Dental problems                          |     |          | Vision problems                 |     |          |

Describe any other important health-related information about your child (for example, feeding tube, oxygen support, hearing aid, 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, 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 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: 

|  |  |  |
|--|--|--|
|  |  |  |
|--|--|--|

| 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 <2 years 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* (Minimum requirements are listed in 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>  | <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<br><b>TB Risk Assessment:</b> <input type="checkbox"/> No Risk <input type="checkbox"/> Positive/Referred<br>Mantoux results: _____ mm | <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 style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Neurological</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Skin</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>Lungs</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Abdomen</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Genital</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>Heart</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Extremities</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Urinary</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><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>EPSDT Screens <u>Required</u> for Head Start – include specific results and date:</b><br>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"/> <b>Unable to test – needs rescreen</b><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"/> <b>Unable to test – needs rescreen</b> |  |                               |                               |                                     |            |

|                      |  |
|----------------------|--|
| <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</b> (check one):<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"/> epi pen <input type="checkbox"/> other: _____ |  |
|   | ___ <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: _____   |  |
|   | ___ <b>Medication.</b> Child takes medicine for specific health condition(s). <input type="checkbox"/> Medication must be given and/or available at school.  |  |
|   | ___ <b>Special Diet</b> Specify: _____   |  |
|   | ___ <b>Special Needs</b> Specify: _____  |  |
|   | ___ <b>Other Comments:</b> _____<br>_____<br>_____   |  |

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