School Health Entrance Form (2007)
Instructions

Part I

Part I is to be completed by the parent or guardian.
Please note that there are three signature lines at the bottom of the page. The first two signatures are required.

1. Inside the box -- signature of the legal guardian or parent: notes authorization for information sharing only.
2. Signature of the person completing the form: this may or may not be the parent or legal guardian; this signature is separate from that authorizing sharing of information.
3. Signature of the Interpreter: needed only if the form was completed with the assistance of an interpreter.

Part II

Instructions for the immunization records are included on the form.

For current immunization requirements consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

Part III

The Code of Virginia requires documentation of a comprehensive physical examination upon entry to public kindergarten or elementary school. The physical examination must be done by a licensed physician, nurse practitioner, or physician assistant, and must be completed no longer than one year before school entry. The physical examination is required to protect the public from communicable disease, and to identify physical, social-emotional, or developmental needs the child has so that (1) the school can begin to prepare to assist those needs, and (2) necessary interventions can be initiated to maximize the child's school readiness. **For these reasons, in order for a child to be admitted to school without delay, *Part I, Part II* and -- at minimum -- the *Recommendations to (Pre) School, Child Care, or Early Intervention Personnel on Part III* must be completed in full.** Local school divisions may require other components. The School Health Entrance Form is also widely used by providers of child care, Head Start, Virginia Preschool Initiative (VPI), and Infant and Toddler Connection (Part C Early Intervention) services. School or other program personnel will contact health care professionals about forms where required sections are incomplete.

The content of the examination is based on *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents*. Wherever possible, the documentation meets expectations for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements. Web-based continuing education modules on ***current*** Bright Futures and EPSDT standards are accessible at www.vcu-cme.org/bf. Revisions to the content of this training are in process to accommodate the new release of Bright Futures later in 2007.

Health Assessment/Physical Examination
Refer to Part I as completed by the parent to assist in taking or clarifying the child's history. Checking the boxes for "age/gender appropriate history" and "anticipatory guidance provided" indicates that you have completed these tasks.

Check the appropriate box for each body system examined using the following guide:
1= Within normal limits
2= Abnormal finding
3= Referred for evaluation or treatment (this indicates the provider has made a direct referral to another provider, or advised the parent to follow up with another provider)

Use the *Recommendations to (Pre) School, Child Care, or Early Intervention Personnel* section to summarize any diagnoses, abnormal findings, or concerns from the physical examination that are of significance.

Perform a risk screen for tuberculosis considering the following risk factors:

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

If the child is not at risk according to one of these factors, check the box for TB Risk Screen Negative. If the child is at risk, check the box for TB Risk Screen Positive; if you then administer a Mantoux test, document the results in the space provided. Some localities ***may require*** TB tests on all children for school or other program entry.

Note: If completing this form for use in Head Start, EPSDT screening and diagnostic tests apply. This includes: blood lead (test at age 1 and 2, or age 3 if not previously done) and a screen for anemia (hemoglobin or hematocrit annually at ages 2 - 5). Record the specific results and the date of each in the spaces provided. For other children, EPSDT lead or anemia screen, or any significant history of abnormal test results, **may** be noted in this section as information to the personnel reviewing the form.

Developmental Screen
Screening for age appropriate development is a critical component of well child care and is integral to identifying children who may need assistance in the school or other structured environment. The established standard of well child care recognizes the use of a tool for assessing development. Examples of tools that have been validated and found to be efficient for use in provider offices include: Parent's Evaluation of Developmental Skills (PEDS), Ages and Sages Questionnaires (ASQ), and Child Development Inventories (CDI). Bright Futures milestones are also used in such screening.

Assessment Method: Indicate the tool or method used to evaluate the child. Note the results:

- Check in the column if findings are within the normal range
- Specify any/all concerns identified in the appropriate row/column

- Check if you referred the child for further evaluation (either made a direct referral to another provider, or advised the parent to follow up)

Hearing Screen

Check the box for the screening method used and indicate the results for each method. Pure tone audiometer should be screened at 20 dB HL in each ear.
Check the boxes as applicable:

- Referred to audiologist/ENT (if child does not pass at the 20 dB level)
- Permanent hearing loss previously identified
- Hearing aid or other assistive device (such as cochlear implant)
- If you are unable to complete a hearing screen check the box "unable to test – needs rescreen"; this will alert school personnel to conduct a hearing screen.

Vision Screen

Check the box indicated if the test was performed with the child wearing corrective lenses.
Indicate the results of a stereopsis screen, if conducted (up to age 9); check the appropriate box if not.
Indicate the results of the distance acuity screen and note the test used; examples include Snellen letters, Snellen numbers, tumbling E chart, Picture tests, Allen figures. Distance testing at 10 feet is recommended.
Check the boxes as applicable:

- Pass
- Referred to eye doctor (worse than 20/40 with either eye if child is 3 – 5 years old, or 20/30 is 6 years or older, or if there is a two-line difference between the eyes even in the passing range)
- If you are unable to complete a vision screen check the box "unable to test – needs rescreen"; this will alert school personnel to conduct a vision screen.

Dental Screen

Dental caries (tooth decay) is the most common chronic disease in children. By the time of school entry, all children should be receiving routine preventive care in a dental office (dental home). Perform a visual examination of the mouth, lifting the lip to observe the condition of the gums. Based on your exam, check the appropriate box:

- Problem Identified: Referred for treatment (there are signs of caries, periodontal disease, soft tissue pathology, or a significant abnormal orthodontic condition requiring additional evaluation or corrective intervention in a dental office)
- No Problem: Referred for prevention (there is no evidence of pathology and the mouth appears normal, but the child is not currently receiving routine preventive dental care)
- No Referral: Already receiving care in a dental home (the mouth appears normal, and the child receives regular dental care as reported by the parent). ***Note:*** the child may have had a single or recent dental visit for an acute problem such as a broken tooth; this alone does not constitute a dental home.

Recommendations to (Pre) School, Child Care, or Early Intervention Personnel

This box communicates specific information about the child to the school or other program he/she will be entering. It is your opportunity to inform the school/program about this child's health status, special needs or considerations, and raise any concerns that may help the school/program prepare for the child. ***This box must be completed in order for the form to be accepted by (pre) school personnel.***

Summary of Findings: Check the box "Well child; no conditions identified of concern to school program activities" if the findings from your examination and screening are all within normal range, or not significant to the child's school entry, e.g., an acute upper respiratory infection. Check the box "Conditions identified that are important to schooling or physical activity" if there were any diagnoses or substantive abnormal findings on your examination or screening that should be flagged for school personnel, e.g., asthma, eczema, heart murmur. Use the space provided to summarize such findings from your exam or screenings.

- **Allergy:** Check the type of allergy, specify the allergen, the type of reaction, and the response required.
- **Individualized Health Care Plan Needed:** Note if a Care Plan is needed for any identified condition such as asthma, diabetes, seizure disorder, severe allergy, etc. The parent will need to collaborate with the child's health care practitioner and provide a Care Plan to school personnel. The Care Plan does not need to accompany this form at the time of enrollment.
- **Restricted Activity**: Indicate any restrictions to physical activity, required assistive devices, or any limitations the child has, of which school personnel need to be aware.
- **Developmental Evaluation**: Note if the child already has an individualized education plan (IEP), or specify any further evaluation needs.
- **Medication:** Note if the child takes medicine, and further note if that medicine must be given or available at school. If this is the case, parents will need to provide the school with authorization. The parent should check with the school for the appropriate form and documentation needed. Authorization does not need to accompany this form at the time of enrollment.
- **Special Diet:** Note special dietary needs that have medical implications, e.g., metabolic restrictions, tube feedings. The parent will need to communicate any special dietary requests to school nutrition services.
- **Special Needs:** Summarize any special health care needs (not otherwise addressed here) of which school personnel should be aware, i.e., oxygen, treatments, etc.
- **Other Comments:** Note any other findings or recommendations that will help school or other program personnel prepare for the child, or assist the child's family.

Health Care Professional's Certification:
Provide the requested information about the provider who completed the exam and practice location contact information. ***The signature line must be completed***; a signature stamp is allowed.

Helpful Web Addresses:
http://www.vahealth.org/schoolhealth/publications.asp
http://www.pen.k12.va.us/VDOE/Instruction/Health/home.html
http://www.dss.virginia.gov/facility/child_care/licensed/child_day_centers/ -- Virginia Child Day Center regulations
http://www.heaststartva.org/resources/index.htm -- Additional resources and links, including federal regulations for Head Start
http://www.vdh.virginia.gov/epidemiology/immunization -- Immunization schedule/requirements
www.vcu-cme.org/bf -- Bright Futures and EPSDT requirements (under revision 2007)

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: _____
Last First Middle

Student's Date of Birth: _____/_____/_____ Sex: _____ State or Country of Birth: _____ 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: |____|____|____|
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 (6th 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 <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) ❑ 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.*):**___/___/____

Student's Name:_____Date of Birth: |____ |_ ___|___ _|

Section II
Conditional Enrollment and Exemptions

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

***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
- ❑ Tdap – booster required for entry into 6th grade if at least 5 years since last tetanus-containing vaccine
- ❑ 3 Polio – 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, for children up to 60 months of age only
- ❑ Pneumococcal – 2-4 doses, depending on age at 1st dose for children up to 2 years of age only
- ❑ 2 Measles – 1st dose on/after 12 months of age; 2nd dose prior to entering kindergarten
- ❑ 1 Mumps – on/after 12 months of age
- ❑ 1 Rubella - on/after 12 months of age
  Note: Measles, Mumps, Rubella requirements also met with 2 MMR – 1st dose on/after 12 months of age; 2nd dose prior to entering kindergarten
- ❑ Hep B – 3 doses required (2 doses if Merck adult formulation given between 11 – 15 years of age; check the indicated box in Section I if this formulation was used)
- ❑ 1 Varicella – to susceptible children born on/after January 1, 1997; dose on/after 12 months of age

*** Additional Immunizations Required at Entry into 6th Grade**

- ❑ Tdap – booster required for entry into 6th grade if at least 5 years since last tetanus-containing vaccine

For current requirements consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

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_____

❑ Age / gender appropriate history completed

❑ Anticipatory guidance provided

TB Risk Assessment: ☐ No Risk ☐ Positive/Referred
Mantoux results: _____mm

Physical Examination

1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment

	1	2	3		1	2	3		1	2	3
HEENT	☐	☐	☐	Neurological	☐	☐	☐	Skin	☐	☐	☐
Lungs	☐	☐	☐	Abdomen	☐	☐	☐	Genital	☐	☐	☐
Heart	☐	☐	☐	Extremities	☐	☐	☐	Urinary	☐	☐	☐

EPSDT Screens Required for Head Start – include specific results and date:
Blood Lead:_____ Hct/Hgb _____

Developmental Screen

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

Hearing Screen

❑ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.

	1000	2000	4000
R			
L			

❑ Screened by OAE (Otoacoustic Emissions): ☐ Pass ☐ Refer

☐ Referred to Audiologist/ENT ☐ **Unable to test – needs rescreen**

☐ Permanent Hearing Loss Previously identified: ___Left ___Right

☐ Hearing aid or other assistive device

Vision Screen

❑ With Corrective Lenses (check if yes)

Stereopsis	❑ Pass	❑ Fail		❑ Not tested
Distance	Both	R	L	Test used:
	20/	20/	20/	

❑ Pass ❑ Referred to eye doctor ❑ **Unable to test – needs rescreen**

Dental Screen

❑ Problem Identified: Referred for treatment

❑ No Problem: Referred for prevention

❑ No Referral: Already receiving dental care

Recommendations to (Pre) School , Child Care, or Early Intervention Personnel

Summary of Findings (check one):
☐ **Well child; no conditions identified of concern to school program activities**
☐ **Conditions identified that are important to schooling or physical activity** (complete sections below and/or explain here): _____

_____

_____

_____

_____

___ **Allergy** ☐ food: _____ ☐ insect: _____ ☐ medicine: _____ ☐ other: _____
Type of allergic reaction: ☐ anaphylaxis ☐ local reaction Response required: ☐ none ☐ epi pen ☐ other: _____

___**Individualized Health Care Plan needed** (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)

___ **Restricted Activity** Specify: _____

___ **Developmental Evaluation** ☐ Has IEP ☐ Further evaluation needed for: _____

___ **Medication**. Child takes medicine for specific health condition(s). ☐ Medication must be given and/or available at school.

___ **Special Diet** Specify: _____

___ **Special Needs** Specify: _____

Other Comments: _____

Health Care Professional's Certification (Write legibly or stamp)**:**

Name : _____ **Signature:** _____ Date: ____/_____/_____

Practice/Clinic Name: _____ **Address**: _____

Phone: _____-_____-_____ **Fax**: _____-_____-_____ **Email:** _____