MCH 213G School Health Entrance Form (Revised 2010) Instructions

Part I-Health Information Form

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. Signature of the legal guardian or parent (located inside the box)- provides written authorization for the child's health care provider and the designated provider of health care in the school setting to discuss the child's health concerns and/or exchange information pertaining to this form.
2. Signature of the person completing the form- this may or may not be the parent or legal guardian.
3. Signature of the Interpreter-needed only if the form was completed with the assistance of an interpreter.

Part II-Certification of Immunization

Instructions for completing *Part II, Sections I and/or II,* are located under each section respectively.

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

Part III-Comprehensive Physical Examination Report

The Code of Virginia requires documentation of a comprehensive physical examination upon entry to public kindergarten or elementary school. The physical examination must be completed by a qualified licensed physician, nurse practitioner, or physician assistant, and must be completed within 12 months prior to the date such child first enters public kindergarten or elementary school. 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 prepare to assist with meeting their needs, and (2) initiate necessary interventions to maximize the child's school readiness. Public school divisions may require additional components. The school entrance health form is also widely used by providers of child care, Head Start, Virginia Preschool Initiative (VPI), and the Infant and Toddler Connection (Part C Early Intervention) services.

The content of the comprehensive physical examination is based on *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents, Third Edition (revised 2008)*. Wherever possible, documentation meets expectations for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements.

Health Assessment
Review Part I-Health Information Form completed by the parent/guardian to assist in taking or clarifying the child's health history. Check the boxes for "age/gender appropriate history completed" and "anticipatory guidance provided" to indicate that you have completed these tasks.

TB Risk Assessment
Risk assessment for tuberculosis should be performed at first contact with a child and every 6 months thereafter for the first 2 years of life. After 2 years of age, risk assessment for tuberculosis should be performed annually, if possible.

Children who should have an annual Tuberculin Skin Test (TST):

- Children infected with HIV
- Incarcerated adolescents

Utilize these validated questions to determine children at risk for acquiring Latent tuberculosis infection (LTBI) in the United States who should be tested with a TST. Is the answer, "yes", to any of these questions:

- Has a family member or contact had tuberculosis disease?
- Has a family member had a positive tuberculin skin test result?
- Was your child born in a high-risk country (countries other than the United States, Canada, Australia, New Zealand, or Western Europe countries?)
- Has your child traveled (had contact with resident populations) to a high-risk country for more than 1 week?

If the answers to all of these risk factor questions is "no", the child is not at risk. Check the box TB Risk Assessment "No Risk". If the answer to any of these risk factor questions is "yes", then the child is at risk. Check the box for TB Risk Assessment "Positive/Referred".
The TST (Mantoux) is the most common method for diagnosing LTBI in asymptomatic people. If you then administer a Mantoux test, document the results in the space provided. (American Academy of Pediatrics. Tuberculosis. In: Pickering LK, Baker CJ, Kimberlin DW, Long SS, eds. *Red Book: 2009 Report of the Committee on Infectious Diseases.* 28th ed. Elk Grove Village, IL: American Academy of Pediatrics: 2009: 680-701 (p 683-685).)

Note: *Some localities **may require** TB tests on all children for school or other program entry.*

Physical Examination
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 (Indicates that the provider has made a direct referral to another provider, or advised the parent/guardian to follow up with another provider)

EPSDT Screens Required for Head Start
EPSDT screening and diagnostic tests are required for students entering Head Start programs. EPSDT screening 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). Document the specific results and the date of each in the spaces provided. For other children, abnormal lead or anemia test results **may** be documented in this section.

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 standardized 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) and Ages and Stages Questionnaires (ASQ). *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 dBHL 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: ____Left ___Right
- 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 (results greater 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. At 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 teeth and mouth, lifting the lip to observe the condition of the gums. Based on your exam findings, 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.

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.

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 communicate 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 (IHP) Needed:** Note if an individualized care plan (IHP) is needed for any identified health condition such as asthma, diabetes, seizure disorder, severe allergy, etc. The parent will need to collaborate with the child's health care provider and provide required physician orders for school personnel. The care plan will be initiated by the school nurse and 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 which needs to be communicated to school personnel.
- **Developmental Evaluation**: Note if the child already has a current individualized education plan (IEP), or specify any further evaluation needs.

- **Medication:** Note if the child routinely takes medication, and further document if medication must be administered while student is at school. If this is the case, parents will need to provide the school with physician orders, parental authorization, and medication/supplies to administer medication. The parent should check with the school for the appropriate form and documentation needed. Parental authorization does not need to accompany this form at the time of enrollment.
- **Special Diet:** Document 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 and/or the school nurse. Parents will need to provide physician orders, parental authorization, and supplies to school personnel.
- **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:** Document 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/childadolescenthealth/- VDH Division of Child and Family Health.
http://www.vahealth.org/childadolescenthealth/schoolhealth/-VDH School Age Health Specialist.
http://www.doe.virginia.gov/support/health_medical/index.shtml- VDOE School Health Specialist.
http://www.dss.virginia.gov/facility/child_care/licensed/child_day_centers/ - Virginia Child Day Center regulations.
http://www.headstartva.org/index.htm - includes additional resources, federal regulations and links.
http://www.vdh.virginia.gov/epidemiology/immunization- VDH immunization schedule/requirements.
www.healthyfuturesva.com– Bright Futures Virginia web site for parents, guardians and care givers.

References-
Hagan JF, Shaw JS, Duncan PM, eds. 2008. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* Third Edition. Elk Grove Village, IL: American Academy of Pediatrics.

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 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, 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 (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

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.)

Certification of Immunization 10/2010

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:** _____