버지니아 커먼웰스
학교 입학 건강 양식
건강 정보 양식/종합 신체 검사 보고서/면역 접종 인증서

파트 I - 건강 정보 양식

주법(참조. 주법(참조. 버지니아 주법 제22.1-270호)은 자녀가 공립 유치원이나 초등학교에 입학하기 전에 예방접종을 받고 종합 신체검사를 받도록 규정하고 있습니다. **부모 또는 보호자가 양식의 이 페이지 (파트 I) 를 작성합니다.** 의료 제공자가 양식의 파트 II 및 파트 III 를 작성합니다. 이

서류는 자녀가 입학하기 1년 전까지 작성되어야 합니다 .

학교 명:_____ 현재 학년: _____

학생 이름: _____

성 이름 중간 이름

학생의 생년 월일:____/____/____ 성별:_____ 출생 주 또는 카운티:_____ 구사하는 기본 언어: _____

학생의 주소_____ 시_____ 주_____ 우편 코드_____

부모 또는 법적 보호자 이름 1:_____ 전화:____-____-____ 직장 전화 또는 휴대폰:____-____-____

부모 또는 법적 보호자 이름 2:_____ 전화:____-____-____ 직장 전화 또는 Cell:____-____-____

비상 연락처:_____ 전화:____-____-____ 직장 전화 또는 휴대폰:____-____-____

병원 선호도: _____

자녀의 건강 보험: 없음□ FAMIS Plus (메디케이드) □ FAMIS □ 개인/상업적/ 의뢰한 고용주 □_____

박스 1. 이미 존재하는 질환

질환질환	예	의견	질환질환	예	의견
알레르기 (식품, 곤충, 약품, 라텍스)			당뇨병: 유형 1		
생명을 위협하는 **알레르기를 기재해 주십시오**:			당뇨병: 유형 2		
			인슐린 펌프		
알레르기 (계절성)			머리 부상, 뇌진탕		
천식 또는 호흡 질환			청각 질환 또는 청각소실		
주의결핍/활동항진 장애			심장 질환		
행동/심리/사회적 질환			납 중독		
발달 장애			근육 질환		
방광 질환			발작		
출혈 질환			겸상 적혈구 질환 (형질이 아님)		
장 질환			언어 질환		
뇌성 마비			척추 손상		
낭성 섬유증			수술		
치과 건강 상태			시력 상태		

자녀에 대한 기타 중요한 건강 관련 정보를 설명하십시오 (□ 영양 공급관 , □ 기도 , □ 산소 공급, □ 보청기, □ 치아 장치, □ 휠체어, 입원, 등):

박스 2. 약

자녀가 정기적으로 복용하는 모든 처방약, 응급약, 일반 의약품, 한약제를 기재하십시오 (집/ 학교):

약 이름	복용량	투여 시간 (집/학교)	참고
1.			
2.			
3.			
4.			

추가 약 (이름, 용량, 투여 시간, 참고 사항)

만약 귀하가 학교 간호사나 다른 학교 관계자와 기밀 정보를 의논하고 싶다면 여기를 확인하세요 . □ 예 □ 아니요 다음 정보를 제공해 주십시오:

	이름	전화	마지막 예약 날짜
소아과 의사/1차 치료 제공자			
전문의사			
치과의사			
사례 관리자 (해당되는 경우)			

본인_____은 자녀의 건강 관리 제공자와 학교 환경에서 지정된 의료 제공자에게 자녀의 건강 문제를 논의하거나 이 양식에 관련된 정보를 교환할 수 있는 권한을 부여 (부여하지 않습니다) . 이 허가는 철회할 때까지 또는 철회하지 않는 한 유효합니다. 귀하는 언제든지 자녀의 학교에 연락하여 허가를 취소할 수 있습니다 . 자녀 기록에서 정보가 공개되면, 자녀 건강 건강기록부나 학력 기록부에 공개 기록이 유지됩니다 .

부모 또는 법적 보호자 서명:_____ 날짜:____/____/____

서명 of 통역사:_____ 날짜____/____/____

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 earlier 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 Code_____

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: _____-_____-_____

Hospital Preference: _____

Child's Health Insurance: None☐ FAMIS Plus (Medicaid) ☐ FAMIS☐ Private/Commercial/ Employer Sponsored☐_____

Box 1. Pre-Existing Conditions

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes: Type 1		
Please list **Life Threatening Allergies**:			Diabetes: Type 2		
			Insulin pump		
Allergies (seasonal)			Head injury, concussion		
Asthma or breathing conditions			Hearing conditions or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart conditions		
Behavioral/Psych/ Social conditions			Lead poisoning		
Developmental conditions			Muscle conditions		
Bladder conditions			Seizures		
Bleeding conditions			Sickle Cell Disease (not trait)		
Bowel conditions			Speech conditions		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental Health conditions			Vision conditions		

Describe any other important health-related information about your child (☐ Feeding tube , ☐ Trach , ☐Oxygen support, ☐ Hearing aids, ☐ Dental appliance, ☐ Wheelchair, Hospitalizations, etc.):

Box 2. Medications

List all prescription, emergency, over-the-counter, and herbal medications your child takes regularly (Home/ School):

Medication Name	Dosage	Time Administered (Home/School)	Notes
1.			
2.			
3.			
4.			

Additional Medications (Name, Dose, Time Administered, Notes)

Check here if you want to discuss confidential information with the school nurse or other school authority. Yes No Please provide the following information:

Type	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

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 Interpreter: _____Date_____/_____/_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Part II - Certification of Immunization

A copy of child's immunization records are attached ☐

Section I

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 official of health department indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording the dates on this page, as long as the completed immunization record is attached to the School Entrance Health Form: Part II Certification of Immunization (MCH213G).

As per 12VAC5-110-70, the Certification of Immunization form must be signed and dated by the Medical Provider (physician or designee, registered nurse, or official of the health department) in the appropriate box below. Contact local health department for assistance with foreign vaccine records.

Student Name: **Date of Birth :** / / **Sex:**

Race (Optional): **Ethnicity:** ☐ **Hispanic** ☐ **Non-Hispanic**

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
Diphtheria, Tetanus, Pertussis Vaccine (DTP, DTaP)	1	2	3	4	5
Diphtheria, Tetanus (DT) or Tdap or Td Vaccine (given after 7 years of age)	1	2	3	4	5
Tdap Vaccine booster	1				
Poliomyelitis Vaccine (IPV, OPV)	1	2	3	4	5
Haemophilus influenzae Type b Vaccine (Hib conjugate) only for children <60 months of age	1	2	3	4	
Rotavirus Vaccine (RV) only for children < 8 months of age	1	2	3		
Pneumococcal Vaccine (PCV conjugate) only for children <60 months of age	1	2	3	4	
Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Measles, Mumps, Rubella Vaccine (MMR vaccine)	1	2			
Measles Vaccine (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
Rubella Vaccine	1	2	Serological Confirmation of Rubella Immunity:		
Mumps Vaccine	1	2	Serological Confirmation of Mumps Immunity:		
Hepatitis **B** Vaccine (HBV) ☐ Merck adult formulation used	1	2	3	4	
Hepatitis **A** Vaccine	1	2			
Meningococcal **ACWY** Vaccine	1	2			
Meningococcal **B** Vaccine	1	2	3		
Human Papillomavirus Vaccine (HPV)	1	2	3		
Influenza (Yearly)	1	2	3	4	5
Other	1	2	3	4	5
Other	1	2	3	4	5

Certification of Immunization

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

A qualified licensed physician, nurse practitioner, or physician assistant must complete the medical exemption or conditional enrollment section as appropriate to include signature and date. This section must be attached to Part I Health Information (to be filled out and signed by parent).

Student's Name: _____ Date of Birth: |____|____|_____|
Parent or Legal Guardian Name: _____
Parent or Legal Guardian Name: _____
Phone Number: _____

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:[____]; PCV:[_____]; RV:[____]; Measles :[_____];

Mumps:[____]; Rubella :[____]; VAR:[_____]; Men ACWY:[____]; Men B:[____]; Hep A:[_____]; HBV:[____]

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 (or 180 days for Hepatitis B). **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 https://www.vdh.virginia.gov/immunization/requirements/

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 and sign 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.vdh.virginia.gov/school-age-health-and-forms/school-health-forms-and-action-plans/

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

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				

Tuberculosis Screening

Check the box that applies:

☐ No risk for TB infection identified	☐ No symptoms compatible with active TB disease	☐ Risk for TB infection or symptoms identified: _____

Test for TB Infection: TST IGRA Date: TST Reading mm TST/IGRA Result: ☐ Negative ☐ Positive

CXR required if positive test for TB infection or TB symptoms. CXR Date:_____ ☐ Normal ☐ Abnormal

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.

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

	1000	2000	4000
R			
L			

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

☐ Permanent Hearing Loss Previously identified: ☐ Left ☐ Right

☐ Hearing aid or another 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

☐ Problems Identified: Referred for Treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

☐ **Unable to perform**

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* ☐ *epinephrine auto-injector* ☐ other::_____

____I**ndividualized 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) ☐ **By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).**

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

Practice / Clinic: **Address:**_____

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