مشترکات د ورجینیا
ښوونځی ننوتل روغتیا فورمه
روغتیا معلومات فورمه/ جامع فزیکی ازموینه راپور/تصدیق د معافیت

**برخه I – روغتیا معلومات فورمه**

د ایالت قانون (Ref. د ویرجینیا کود § 22.1-270) دي ته اړتیا لري چې باید ستاسو ماشوم واکسین شوی وي او خلکو ته له ورتګ وړاندې یوه پراخه فزیکي معاینه ترلاسه کوي ورکټون یا ابتدایي ښوونځی. والدین باید سرپرست بشپړوي دغه پاڼه (برخه**I**) له د فورمه. د طبي چمتو کوونکی بشپړوي برخه II او برخه III له دغه فورمه. دغه فورمه باید وي بشپړه شوینه وړاندې له یوه کال مخکې ستاسو د ماشوم له ننولو په ښوونځي کې.

نوم د ښوونځي:_____ اوسنی ټولګی:_____

د زده کونکو نوم:

_____

ورستی لومړنی منځنی

ایالت یا هېواد د د زېږدلو:_____ اصلي ژبه ویل شوي:_____ جنسیت:_____ د زده کونکي نېټه د زېږدلو:_____/_____/_____

د زده کوونکي پته_____ښار_____ایالت_____زپ کود_____

نوم د والدین یا قانوني سرپرست1 :_____تلیفون:_____-_____-_____کار یا ګرځنده:_____-_____-_____

نوم د والدین یا قانوني سرپرست2 :_____تلیفون:_____-_____-_____کار یا ګرځنده:_____-_____-_____

عاجل تماس:_____تلیفون:_____-_____-_____کار یا ګرځنده:_____-_____-_____

شفاخانه ترجیح:_____

د ماشوم روغتیا بیمه: یو هم نه□ فامیس جمع (مېډیکېډ) □ فامیس □ شخصي/سوداګریز / د کارځښتن سپارنسرشوي□_____

| بکس**1** . مخکې موجود شرایط | | | | | |
|---|---|---|---|---|---|
| نظرونه | هو | شرایط | نظرونه | هو | شرایط |
| | | د شکر ناروغي: دول1 | | | الرجی (غذا, حشرات, نشه یي توکي, لاتکس) |
| | | د شکر ناروغي: دول2 | مهرباني وکړئ لیست کړی د ژوند ګواښونکي الرجي: | | |
| | | انسولین پمپ | | | |
| | | سر زخمي کېدل, مغزي ضربه | | | الرجی (موسمي) |
| | | د اورېدلو شرایط یا کاپوالی | | | اسما یا د تنفس ګولو شرایط |
| | | د رڑه حالت یا شرایط | | | د نوجه کمښت/ډیر فعالیت کډوډي |
| | | رهیري زهري ګول | | | چلند/روانې/ټ شرایط |
| | | عضلاتي شرایط | | | پرمختیایي شرایط |
| | | تشنج (هغه ناروغي چې عاجل انسان نیسي) | | | د مثانې شرایط |
| | | داس د حجرو ناروغي (نه صفت) | | | خونریزي شرایط |
| | | د خیرو شرایط | | | د ګولمو شرایط |
| | | نخاع ټپ | | | دماغي فلج |
| | | جراحي | | | سیستیک فیبروز |
| | | لیډ شرایط | | | د غاښونو روغتیا شرایط |

تشریح کړئ نور مهم روغتیایي-مربوط معلومات په اړه ستاسو د ماشوم (□ د تغذیې ټیوب , □ تریچ , □ اوکسیجن ملاتړ, □ اورېدل کمکونه, □ د غاښونو وسیله, □ ځرخ, روغتونونه کې بستر کېدل, او داسې نور.):

| بکس**2** . درمل<br>لیست کړی ټول نسخه, عاجل, بې نسخې, او بوتې درمل ستاسو ماشوم اخلي منظیم ly(کور/ښوونځی): | | | |
|---|---|---|---|
| یادداښت ونه | وخت اداره کیږي (کور/ښوونځي) | د درملو خوراک | درمل نوم |
| | | | .1 |
| | | | .2 |
| | | | .3 |
| | | | .4 |
| اضافي درمل (نوم, دور, وخت اداره سوی, نویونه) | | | |

چک کړئ دلته که چېرې تاسو غواړئ چې بحث وکړئ په محرمانه ډول معلومات له د ښوونځي نرس یا نور ښوونځي چارواکي. □ هو □ نه مهرباني وکړئ چمتو کړئ د راتلونکي معلومات:

| نېټه د روستني لیدنې د وخت | تلیفون | نوم | |
|---|---|---|---|
| | | | د ماشومانو ډاکټر/لومړنی پاملرنه چمتو کونکی |
| | | | ماهر |
| | | | د غاښونو ډاکټر |
| | | | قضیه کارکونکی (که چیرې د پلي کېدلو وړ وي) |

زه _____(*do*) (کړم نه) صلاحیت نه ورکوم زما ماشوم ته روغتیا د پاملرنې چمتوکونکی او ټاکل شوی چمتو کونکی د روغتیا پاملرنه په د ښوونځي ترتیب ته بحث زما د ماشوم روغتیا اندښنې او/یا تباده معلومات اړوند ته دغه فورمه. دغه د صلاحیت به وی په ځای تر یا لږترلږه تاسو وباسئ هغه. تاسو ممکن وباسئ ستاسو صلاحیت په هر وخت له تماس نیولو ستاسو د ماشوم ښوونځي. کله چې معلومات دي خپاره شي له ستاسو د ماشوم ریکارډ, اسنادو له د افشاکونکو دی ساتل شوي په ستاسو د ماشوم روغتیا یا علمي ریکارډ.

لاسلیک د والدینو یا قانوني سرپرست: _____ نېټه: _____ / _____ / _____

لاسلیک د شفاهي ژباړونکي: _____ نېټه _____ / _____ / _____

# 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:**_____