弗吉尼亚 政府联邦
入学健康表
健康信息表/综合体检报告/免疫接种证明

第一部分 – 健康信息表

州法律（弗吉尼亚州法典编号 **§ 22.1-270）要求您的孩子在进入公立幼儿园或小学之前进行免疫接种并接受全面体检。**
家长或监护人请填写表格的第一部分。 医疗提供者请填写表格的第二部分和第三部分。 该表格 必须 在您的孩子入学前一年内完成。

学校名称：_____所在年级：_____

学生姓名：_____
姓 名 中名

学生的出生日期：____/____/____ 性别：____ 出生州或国：_____主要语言：_____

学生住址_____城市_____州_____邮政编码_____

父母或法定监护人1的姓名：_____电话：____-____-____工作或电话：____-____-____

父母或法定监护人2的姓名：_____电话：____-____-____工作或电话：____-____-____

紧急联络人：_____电话：____-____-____工作或电话：____-____-____

医院偏好：_____

儿童健康保险： 无 □ FAMIS Plus (医疗补助制度) □ FAMIS □ 私人/商业/雇主赞助□ _____

框1. 已存在的医疗状况

状况	是	备注	状况	是	备注
过敏反应（食物、昆虫、药物、乳胶） 请列出 **威胁生命的过敏反应：**			糖尿病：类型1		
			糖尿病：类型2		
			胰岛素泵		
过敏反应（季节性）			颅脑损伤、脑震荡		
哮喘或呼吸状况			听力状况或耳聋		
注意力缺陷多动症障碍			心脏状况		
行为/心理/社交状况			铅中毒		
发展状况			肌肉状况		
膀胱状况			癫痫		
血液状况			镰状细胞病（非特征性）		
肠道状况			言语状况		
脑性瘫痪			脊髓损伤		
囊性纤维化			外科手术		
牙齿健康状况			视力状况		

描述关于您孩子的任何其他重要健康相关信息 (□ 喂食管、 □ 气管、 □ 供氧支持、□ 听力辅助、□ 腔矫治器、□ 轮椅、 住院治疗等):

框2. 药物
列出您孩子ding服用的所有处方药、急救药、非处方药和草药（家/学校）：

药物名称	剂量	用药时间（家/学校）	备注
1.			
2.			
3.			
4.			

其他药物（名称、剂量、给药时间、备注）

如果您想与学校护士或其他学校主管部门讨论机密信息，请点击此处。 □ 是 □ 否 请提供以下信息：

	姓名	电话	上次预约日期
儿科医生/初级保健提供者			
专家			
牙医			
工作人员（如适用）			

我_____同意（不同意）授权我孩子的医疗保健提供者和学校环境中指定的医疗保健提供者讨论我孩子的健康问题和/或交换与本表格有关的信息。 此授权将一直有效，直到或除非您撤销。 您可以随时联系您孩子的学校撤销授权。
当信息从您的孩子的记录中发布时，披露的文件保存在您的孩子的健康或学业记录中。

父母或法定监护人签字：_____日期：_____/_____/_____ 口译员签字：_____日期____/_____/_____

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:**_____