# COMMONWEALTH OF VIRGINIA
# FORMULARIO DE SALUD PARA ADMISIÓN ESCOLAR

**Formulario de información de salud/ Reporte de examen físico/ Reporte de inmunizaciones**

## Parte I- FORMULARIO DE INFORMACION DE SALUD

La ley estatal (ref. *Código de Virginia* § 22.1-270) requiere que su hijo(a) esté completamente inmunizado y se haga un examen físico antes de entrar al kínder o a la primaria de las escuelas públicas. **Los padres o tutores rellenan ésta página (parte I) del formulario.** El proveedor de salud rellena las partes II y III del formulario. Este formulario debe ser completado dentro de un año antes del primer día de clases de kindergarten o escuela primaria de su hijo(a).

Nombre de la escuela: _____ Grado: _____

Nombre de estudiante: _____
Apellido Primer nombre Segundo nombre

Fecha de nacimiento del estudiante: ____/____/____ Sexo: _____ País de nacimiento: _____ Idioma principal hablado: _____
Dirección del estudiante: _____ Ciudad: _____ Estado: _____ Código Postal: _____
Nombre de la madre o tutor legal: _____ Tel. de la casa ____-____-_____ Tel. del trabajo o celular: ____-____-_____
Nombre del padre o tutor legal: _____ _Tel. de la casa _____-____-_____ Tel. del trabajo o celular: _____-_____-_____

Contacto de emergencia: _____ Tel. de la casa_____-_____-_____ Tel. del trabajo ó Celular: _____-_____-_____

| Condición | Sí | Comentario | Condición | Sí | Comentario |
|---|---|---|---|---|---|
| Alergias(comida,insectos,medicinas,látex) | | | Diabetes | | |
| Alergias de la temporada | | | Lesiones en la cabeza o espina dorsal | | |
| Asma o problemas de respiración | | | Problemas de la audición o sordera | | |
| Problemas de atención/ Hiperactividad | | | Problemas del corazón | | |
| Problemas de conducta | | | Hospitalizaciones | | |
| Problemas de desarrollo | | | Envenenamiento con plomo | | |
| Problemas de la vejiga | | | Problemas musculares | | |
| Problemas de hemorragias | | | Convulsiones | | |
| Problemas intestinales | | | Enfermedades de las células | | |
| Parálisis cerebral | | | Problemas del habla | | |
| Fibroma cístico | | | Cirugías | | |
| Problemas dentales | | | Problemas de la visión | | |

Describa cualquier otra información importante relacionada con la salud de su hijo(a) (ej. sonda de alimentación, dispensador de oxígeno, dispositivo para la audición, etc.)

_____
_____

Indique todas las medicinas recetadas, de venta sin receta e hierbas medicinales que su hijo(a) toma regularmente: _____
_____

Marque aquí si desea conversar sobre información confidencial con la enfermera de la escuela u otra autoridad escolar: ☐ Sí ☐ No

Por favor, proporcione la siguiente información:

| | Nombre | Teléfono | Fecha de la última cita |
|---|---|---|---|
| Pediatra o doctor de cabecera | | | |
| Especialista | | | |
| Dentista | | | |
| Trabajador social (si corresponde) | | | |

Seguro médico de su hijo(a): _____ Ninguno _____FAMIS Plus (Medicaid) ____ Privado/comercial/patrocinado por el empleador

**Yo, _____ (autorizo _____) (no autorizo _____) que la persona designada a cargo de la salud en la escuela se comunique con el médico o proveedor de salud de mi hijo/a si tiene preguntas o necesita información acerca de este formulario.** *Esta autorización estará en efecto a menos que usted la remueva. Usted puede removerla en cualquier momento poniéndose en contacto con la escuela de su hijo(a). Si alguna vez se divulga información acerca de su hijo(a) se documentará y registrará dicha divulgación en el archivo escolar.*

Firma del padre o tutor legal: _____ Fecha : _____/_____/_____

Firma de la persona que rellenó este formulario: _____ _____ Fecha : _____/_____/_____
Firma del Intérprete: _____ Fecha : _____/_____/_____

**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 <60 months 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* (Reference 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.)**

## 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

**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 | ☐ | ☐ | ☐ |

**TB Screening: ☐ 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: ☐ Positive ☐ Negative**
**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.

| | 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 ☐ epinephrine auto-injector ☐ 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) ☐ **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 Name**:_____**Address**: _____

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