APPENDIX D: REQUIRED FORMS

♦ School Entrance Health Form: Health Information Form/Comprehensive Physical Examination Report/ Certificate of Immunization (MCH-213D, Rev.1/99).

♦ School Entrance Physical Examination and Immunization Certification Form (MCH-213C, Rev.10/91).

♦ Immunization Record, Virginia Department of Health (MCH-213C-Supplement).

♦ Certificate of Religious Exemption, Commonwealth of Virginia (CRE-1).

♦ Student Immunization Status Report (Form SIS-1).

♦ School Entrance Health Information Form (HPE-h12 12/83).

♦ Athletic Participation Parental Consent Physical Examination Form.

♦ Cumulative Health Record (Form LF.009).

♦ Summary of Vision and Hearing: Report to the Principal (Form LF.011, 3/95).


♦ Scoliosis Report, Virginia Department of Education.
COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

Health Information Form / Comprehensive Physical Examination Report / Certification of Immunization

Part I - HEALTH INFORMATION FORM

Part I to be completed by parents or guardians of entering students. Ref. Code of Virginia § 22.1-270, l.

Student's Name:__________________________________________

Student's Date of Birth: ______ / ______ / ______ Sex: ______ Number of Children in Family: ______ State or Country of Birth: ______

Student's Social Security #: ___________________________ or I.D. #: ___________________________

Student's Address: ____________________________________________ City: __________ State: ______ Zip: ______

Name of School: ____________________________________________ Grade: ______

Name of Mother or Legal Guardian: ____________________________

Home Phone: ______ - ___________ Work Phone: ______ - ___________

Name of Father or Legal Guardian: ____________________________

Home Phone: ______ - ___________ Work Phone: ______ - ___________

In case of emergency—if parent or guardian cannot be contacted—contact the following:

1. Name: ____________________________ Complete Phone Number: ______ - ______ - ______ - ______

2. Name: ____________________________ Complete Phone Number: ______ - ______ - ______ - ______

Birth History (weight, premature, and any other problems at birth):

ALLERGIES (food, medicine, insect bites, and any other allergies):

<table>
<thead>
<tr>
<th>Equipment Used and Specialized Health Care Needed</th>
<th>Chronic, Recurring, and Special Health Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Check all that apply and explain below: * )</td>
<td>(Check all that apply and explain below: * )</td>
</tr>
<tr>
<td>Equipment Used by Child:</td>
<td>Arthritis (rheumatoid)</td>
</tr>
<tr>
<td>Glasses / Contact Lens</td>
<td>Asthma</td>
</tr>
<tr>
<td>Hearing Aid</td>
<td>Attention-Deficit/Hyperactivity Disorder</td>
</tr>
<tr>
<td>Helmet</td>
<td>Behavioral or Developmental Problems</td>
</tr>
<tr>
<td>Wheelchair / Walker</td>
<td>Cerebral Palsy</td>
</tr>
<tr>
<td>Medical Support Systems</td>
<td>Cystic Fibrosis</td>
</tr>
<tr>
<td>Other</td>
<td>Mechanical Ventilator</td>
</tr>
<tr>
<td>Hickman / Broviac / IVAC / IMED</td>
<td>Dental Problems</td>
</tr>
<tr>
<td>Oxygen</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Specialized Health Care Needed:</td>
<td>Encopresis (involuntary discharge of stool)</td>
</tr>
<tr>
<td>Venticular Peritoneal Shunt</td>
<td>Enuresis (involuntary discharge of urine)</td>
</tr>
<tr>
<td>Activities of Daily Living:</td>
<td>Head or Spinal Injury</td>
</tr>
<tr>
<td>Bowel / Bladder Training</td>
<td>Hearing Impairment</td>
</tr>
<tr>
<td>Ostomies</td>
<td>Other Heart Disease</td>
</tr>
<tr>
<td>Upping / Tolting</td>
<td>Other Respiratory Assistance</td>
</tr>
<tr>
<td>Ostomy Care</td>
<td>Kidney Disease</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

*Explanation:

Describe any family history of chronic illnesses or genetic concerns (please list family member in relation to child [e.g., mother] and name of condition [e.g., arthritis, cancer, diabetes, heart disease, high blood pressure, kidney disease, mental illness, stroke, tuberculosis]):

List names of medical specialists or special clinics caring for your child:

Has your child ever been seen by a dentist? Yes: ___________ No: ______. If yes, date of last appointment: ________ Name of dentist: ________

List all prescription and over-the-counter medications taken regularly by your child:

Describe your child's operations and hospitalizations, if any (reason and date):

Describe any other important health-related information about your child:

Check here if you want to discuss confidential information with school nurse or other school authority: Yes: ______. No: ______

Check here if you give permission for the school nurse or other school authority to contact the examining physician to discuss any information contained on this form: Yes: ______. No: ______

Signature of Parent or Legal Guardian: ____________________________ Date (Mo., Day, Yr.): ________

MCH-213 D, PART I, REV. 1/99
# Part II - COMPREHENSIVE PHYSICAL EXAMINATION REPORT

Part II to be completed by a qualified licensed physician. All components, unless otherwise indicated, are to be performed no earlier than twelve months prior to the date child enters kindergarten or elementary school. Ref. Code of Virginia § 22.1-270, A-H.

**Student’s Name:**

**Date of Birth:**

**Height:**

**Weight:**

**Head Circumference:**

**Blood Pressure:**

**Hemoglobin:**

**gms or Hematocrit:**

**%:**

**Urine: Albumin:**

**Sugar:**

**Other:**

**Results of Mantoux tuberculin skin test, optional (may be required in high-risk groups):**

**mm.**

**Date of test:**

**If performed, date of most recent blood lead level:**

**μg/dl.**

**Distance visual acuity screening results, without correction:**

**Right Eye 20/**

**Left Eye 20/**

**Both Eyes 20/**

**Distance visual acuity screening results, with correction:**

**Right Eye 20/**

**Left Eye 20/**

**Both Eyes 20/**

**If performed, stereopsis screening results:**

**Pass**

**Fail**

**Child to be rescreened?**

**Yes [  ], No [  ]**

**Child to be referred?**

**Yes [  ], No [  ]**

**Hearing screening results:**

**Right Ear**

**Left Ear**

**Equipment used:**

**If performed, hearing evaluation results:**

**Right Ear**

**Left Ear**

**If indicated, Tympanogram:**

**Normal**

**Abnormal**

**Child to be rescreened?**

**Yes [  ], No [  ]**

**Child to be referred?**

**Yes [  ], No [  ]**

<table>
<thead>
<tr>
<th>Systems Examination</th>
<th>Examined</th>
<th>Not Examined</th>
<th>Comments About Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Appearance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional Status</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Posture / Motor Behavior</td>
<td></td>
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<tr>
<td>Skin</td>
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<td>Head</td>
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<tr>
<td>Eyes:</td>
<td>External</td>
<td>Fundi</td>
<td></td>
</tr>
<tr>
<td>Ears:</td>
<td>External and Canal</td>
<td>Tympanic Membrane</td>
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<td>Nose</td>
<td></td>
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<td>Throat</td>
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<tr>
<td>Mouth / Teeth</td>
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<tr>
<td>Neck</td>
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<tr>
<td>Heart</td>
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<tr>
<td>Lungs</td>
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<tr>
<td>Abdomen</td>
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<tr>
<td>Genitalia (Tanner Stage)</td>
<td></td>
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</tr>
<tr>
<td>Bones, Joints, Muscles</td>
<td></td>
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</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated Developmental Level:</td>
<td>Cognitive Development</td>
<td>Speech / Language Development</td>
<td>Social / Emotional Development</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Summary of abnormal physical findings, if any:**

___________________________

**Medical diagnoses:**

___________________________

Describe specifically what, if any, conditions are found that would identify the child as having a disability, including conditions that might require (1) educational evaluation, (2) environmental adjustment, or (3) activity limitation:

___________________________

**Assessment:**

___________________________

**Recommendations and referrals made, if any:**

___________________________

___________________________

___________________________

___________________________

**Physician’s Address:**

**City:**

**State:**

**Zip:**

___________________________

**Physician’s Name (print):**

**Phone No.:**

___________________________

___________________________

___________________________

**Signature of Physician:**

___________________________

**Date (Mo., Day, Yr.):**

___________________________

MCH-213 D, PART II, REV. 1/99
### IMMUNIZATION

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Record Complete Dates (month, day, year) of Vaccine Doses Given</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria, Tetanus, Pertussis (DTP, DTaP)</td>
<td>1, 2, 3, 4, 5</td>
</tr>
<tr>
<td>Diphtheria, Tetanus (DT) or Td (given after 7 years of age)</td>
<td>1, 2, 3, 4, 5</td>
</tr>
<tr>
<td>Poliomyelitis (OPV or IPV)</td>
<td>1, 2, 3, 4, 5</td>
</tr>
<tr>
<td>Haemophilus influenza Type b (Hib Conjugate Vaccine)</td>
<td>1, 2, 3, 4, 5</td>
</tr>
<tr>
<td>Measles (Rubella)</td>
<td>1, 2, 3, 4 Serological Confirmation of Measles Immunity:</td>
</tr>
<tr>
<td>Rubella</td>
<td>1, 2, 3, 4 Serological Confirmation of Rubella Immunity:</td>
</tr>
<tr>
<td>Mumps</td>
<td>1, 2, 3, 4 Other (List type and date received):</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella (MMR vaccine)</td>
<td>1, 2, 3, 4</td>
</tr>
<tr>
<td>Hepatitis B Vaccine (HBV)</td>
<td>1, 2, 3, 4 Other:</td>
</tr>
<tr>
<td>Varicella Vaccine</td>
<td>1, 2, 3, 4 Other:</td>
</tr>
<tr>
<td>Rotavirus Vaccine</td>
<td>1, 2, 3, 4 Other:</td>
</tr>
</tbody>
</table>

### MEDICAL EXEMPTION
As specified in the Code of Virginia § 22.1-271.2, C (i), 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[ ]; DTT/d[ ]; OPV/IPV[ ]; Hib[ ]; HBV[ ]; Measles[ ]; Mumps[ ]; Rubella[ ]; Varicella[ ]

This contraindication is permanent [ ] or temporary [ ] and expected to preclude immunizations until: Date (Mo., Day, Yr.): [ ]

Signature of Physician or Health Department Official: [ ]

### 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).

I certify that this student has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this student has a plan for the completion of his/her requirements within the next 90 days (conditional enrollment):

Signature of Physician or Health Department Official: [ ]

I certify that this student is ADEQUATELY IMMUNIZED in accordance with the MINIMUM requirements for attending school prescribed by the State Board of Health's Regulations for the Immunization of School Children (For information or questions on immunization regulations, please call your local health department or the Virginia Department of Health, Division of Immunization, at 1-800-568-1929):

Signature of Physician or Health Department Official: [ ]
VIRGINIA SCHOOL HEALTH GUIDELINES

Note. This form was replaced by MCH 213D, Rev. 1/99, effective on date MCH 213D became available.

PART I
COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE PHYSICAL EXAMINATION AND IMMUNIZATION CERTIFICATION
HEALTH INFORMATION SECTION: (PART I to be completed by parent or guardian) Please Print or Type! Thank you.

Student's Name ____________________________

Complete Date of Birth ___________ / _______ / ______

Number of Children in Family ______

State or Country of Birth

Social Security # _______ / _______ / ______

Parent or Legal Guardian: ____________________________

Address: ____________________________

City: ____________________________

Zip: ______

Home Phone: ______

Work Phone: ______

School's Name: ____________________________

In case of emergency, notify: (other than parent or guardian) Please list Name, address, and Complete Phone Number (area code and number):

1) ____________________________

Phone: ______

2) ____________________________

Phone: ______

Birth History (weight, prematurity, any other problems at birth): ____________________________

Allergies to food, medicines, insect bites/alarms, or other: ____________________________

// Check here if you wish to discuss confidential information with school authorities.

EQUIPMENT USED BY CHILD (please check those that apply) CHRONIC OR RECURRING CONDITIONS (please check those that apply)

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthetics (e.g., cane, crutch, limb)</td>
<td>Ear Infections</td>
</tr>
<tr>
<td>Brace</td>
<td>Hard of Hearing</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Seizures/epilepsy</td>
</tr>
<tr>
<td>Glasses</td>
<td>Kidney Disease</td>
</tr>
<tr>
<td>Helmet</td>
<td>Sickle Cell Anemia (not trait)</td>
</tr>
<tr>
<td>Wheelchair or Walker</td>
<td>Head, spinal cord injury, or disease of central nervous system</td>
</tr>
<tr>
<td>Special Shoes</td>
<td>Eye Disease</td>
</tr>
<tr>
<td>Other (Please List):</td>
<td>Heart Disease</td>
</tr>
<tr>
<td>Other (Please List):</td>
<td>Asthma</td>
</tr>
<tr>
<td>Other (Please List):</td>
<td>Diabetes</td>
</tr>
</tbody>
</table>

Names of medical specialists, dentists, or special clinics caring for child: ____________________________

Prescription medicines taken regularly (LIST): ____________________________

Operations (dates): ____________________________

Hospitalizations (dates): ____________________________

Other important information about your child: ____________________________

I give my permission for the school nurse/school to contact the examining physician to discuss any information contained on this form.

Signature of Parent/Legal Guardian: ____________________________ Date (mm/dd/yy): ______

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PART II
CERTIFICATION OF SCHOOL HEALTH EXAMINATION
PART II TO BE COMPLETED BY A PHYSICIAN
(Reverse to be completed by parent/guardian)

Student's Name: ______________________________

Birth Date: / / 

Height: ________________________________ Weight: ________________________________

Head Circumference: ________________________________ BP: ________________________________

Hematocrit: ________________________________ Urine Albumin: ________________________________ Sugar: ________________________________ Others: ________________________________

Most recent Tuberculin Test Date: / / ; Result: ________________________________ Hearing R: ________________________________ L: ________________________________

Vision (w/o glasses) R: ________________________________ L: ________________________________ Hearing test performed? Audigram: ________________________________ Voice: ________________________________

Vision (w/ glasses) R: ________________________________ L: ________________________________ Tympanogram (if indicated): normal ____________ absent ____________

<table>
<thead>
<tr>
<th>Systems Examination</th>
<th>Exam.</th>
<th>Not Exam.</th>
<th>Comments About Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Appearance, Nutrition</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Posture, Gait</td>
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<td>Skin</td>
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<td>Head</td>
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<td>Ear External &amp; Canal</td>
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<td>Other:</td>
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<tr>
<td>Est. of developmental level</td>
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<tr>
<td>Behavioral Observations</td>
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<tr>
<td>Cooperation</td>
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<tr>
<td>Emotional Tone</td>
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<td></td>
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<tr>
<td>Activity Level</td>
<td></td>
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</tr>
</tbody>
</table>

Summary of abnormal conditions which may require: (a) Educational evaluation, (b) Environmental adjustment, or (c) Activities to be limited.

Referrals made: ________________________________

Physician (print): ________________________________ Signature: ________________________________ Date: / / 

Address: ________________________________ Phone: ________________________________

MCH-213C;Rev.10/91

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PART III

CERTIFICATION OF IMMUNIZATION

Part III is to be Completed by a Physician or Health Department Official

Student's Name: ____________________________  DOB(____/____/____)

Student's S.S. #: ___________________________  ID #: __________________

Parent/Guardian:

<table>
<thead>
<tr>
<th>IMMUNIZATIONS</th>
<th>RECORD COMPLETE DATES (month/day/year) OF VACCINE DOSES ADMINISTERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicella (Chicken Pox/Varicella)</td>
<td>12/12/11</td>
</tr>
<tr>
<td>Diptheria/Tetanus (DT or Adult DT)</td>
<td>12/12/11</td>
</tr>
<tr>
<td>Polio Oral Vaccine (OPV or tOPV)</td>
<td>12/12/11</td>
</tr>
<tr>
<td>Measles (Rubella)</td>
<td>12/12/11   12/12/11   Confirmation of Measles Immunity 12/12/11</td>
</tr>
<tr>
<td>Rubella</td>
<td>12/12/11   12/12/11   Confirmation of Rubella Immunity 12/12/11</td>
</tr>
<tr>
<td>Mumps</td>
<td>06/01/11   06/01/11   Child Entered School Before 06/01/11</td>
</tr>
<tr>
<td>Meningitis, Mumps, Rubella (MMR)</td>
<td>06/01/11   06/01/11   Other 06/01/11</td>
</tr>
<tr>
<td>Hepatitis B Vaccine</td>
<td>12/12/11   12/12/11   Other 12/12/11</td>
</tr>
</tbody>
</table>

Hemophilus influenzae Type b (Hib Conjugate): PLEASE COMPLETE THE APPROPRIATE SECTION BELOW.

/ / Has received complete series of Hib vaccine in accordance with current recommendations of the AMERICAN ACADEMY OF PEDIATRICS or THE U.S. PUBLIC HEALTH SERVICE.

/ / Has received the AGE-APPROPRIATE doses of Hib vaccine as recommended by the AMERICAN ACADEMY OF PEDIATRICS or THE U.S. PUBLIC HEALTH SERVICE, the series will be completed on (RECORD COMPLETE DATE (month/day/year)):

Series Completion Date: / / / / 06/01/11

/ / Hib vaccine is not indicated because this child has had Hib disease at 24 months of age or older.

/ / Being over 50 months of age, this child is not required by law to have proof of immunization against Hib.

MEDICAL EXEMPTION: DTP/ h  Td/ h  OPV/ h  Hib/ h  Measles/ h  Mumps/ h  Rubella/ h

As specified in 22.1-372.2(a)(i) of the Code of Virginia, I certify that administration of the vaccine(s) designated above would be detrimental to this student’s health. The vaccine(s) is (are) specifically contraindicated because (please specify):

This contraindication is permanent / or temporary / and expected to preclude immunization until ____________________

Signature of Physician or Health Dept. Official: ____________________________  Date: / / / / 06/01/11

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 officer stating that the administration of immunizing agents conflicts with the student’s religious tenets or practices. Any student entering school for the first time after July 1, 1983, 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 22.1-372.2, CJ, CODE OF VIRGINIA

I certify that this student has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this student has a plan for the completion of his/her requirements within the next 90 days (conditional enrollment).

Signature of Physician or Health Dept. Official: ____________________________  Date: / / / / 06/01/11

I certify that this student is ADEQUATELY IMMUNIZED in accordance with the MINIMUM requirements for attending school prescribed by the State Board of Health on the reverse side of this form.
PART IV

MINIMUM IMMUNIZATIONS REQUIRED OF NEW STUDENTS BY THE
STATE BOARD OF HEALTH
FOR
*SCHOOL ATTENDANCE

**DTP:** THREE (3) doses of DTP with one (1) of the three (3) administered after the fourth birthday. If any of these doses must be administered on or after the seventh birthday, ADULT Td should be used instead of DTP.

**OPV:** THREE (3) doses of trivalent OPV with one of the three administered after the fourth birthday or three (3) doses of eIPV with one of the three administered after the fourth birthday.

**MEASLES:** TWO (2) doses of live virus measles (rubeola) vaccine, one dose given at 12 months of age or older and a second dose administered prior to entering KINDERGARTEN or first grade, whichever occurs first, effective JULY 1, 1991.

**RUBELLA:** ONE (1) dose of rubella vaccine received at 12 months of age or older.

**MUMPS:** ONE (1) dose of mumps vaccine received at 12 months of age or older for students entering school on or after AUGUST 1, 1981.

*SCHOOL DEFINITION:* a) Any public school from kindergarten through grade 12 operated under the authority of any locality within this Commonwealth; b) Any private or parochial school that offers instruction at any level or grade from kindergarten through grade 12; c) Any private or parochial nursery school or preschool, or any private or parochial child care center licensed by this Commonwealth; and d) Any preschool handicapped classes or Head Start classes operated by the school divisions within this Commonwealth.

If there are questions please call your local health department.
**IMMUNIZATION RECORD**

**VIRGINIA DEPARTMENT OF HEALTH**

Name: ____________________________ DOB: ____________

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date 1</th>
<th>Date 2</th>
<th>Date 3</th>
<th>Date 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria/Tetanus/Pertussis (DTP)</td>
<td></td>
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<tr>
<td>Diphtheria/Tetanus (DT or Adult Td)</td>
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<tr>
<td>Poliomyelitis (OPV or eIPV)</td>
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<tr>
<td>Measles (Rubeola)</td>
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<tr>
<td>Rubella</td>
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<td></td>
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<tr>
<td>Mumps</td>
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<tr>
<td>Measles, Mumps, Rubella (MMR)</td>
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<tr>
<td>Hepatitis B Vaccine</td>
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<tr>
<td>Haemophilus Influenza type b (Hib)</td>
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</tbody>
</table>

Serological Confirmation of Measles Immunity

Serological Confirmation of Rubella Immunity

*Child Entered School Before 08/01/81
*(Mumps vaccine is not required if the child entered school before 08/01/81)

This is an official replication of the vaccination record for the above patient. Dates of immunizations listed above or either dates of vaccinations given or dates recorded with the Virginia Department of Health by the Patient.

Public Health Official

MCH 213C-SUPPLEMENT
COMMONWEALTH OF VIRGINIA
CERTIFICATE OF RELIGIOUS EXEMPTION

Name_________________________________________ Birth Date________

Student I.D. Number________________________________________

The administration of immunizing agents conflicts with the above named student's/my religious tenets or practices. I understand, that in the occurrence of an outbreak, potential epidemic or epidemic of a vaccine-preventable disease in my/my child's school, the State Health Commissioner may order my/my child's exclusion from school, for my/my child's own protection, until the danger has passed.

_________________________________________ ______________________
Signature of parent/guardian/student Date

I hereby affirm that this affidavit was signed in my presence on

this______________________________ day of ______________________

Notary Public Seal

Form CRE-1; Rev. 09/92
COMMONWEALTH OF VIRGINIA
STUDENT IMMUNIZATION STATUS REPORT

PLEASE TYPE OR PRINT ALL INFORMATION!

FACILITY: ____________________________
MAILING ADDRESS: ____________________________
CITY: ____________________________ ZIP: _______
LOCATION: STREET: ____________________________
COUNTY: ____________________________ CITY: ____________________________
PERSON PREPARING REPORT (PRINT): ____________________________ TITLE: __________
SIGNATURE: ____________________________ DATE: __________ PHONE: __________

TYPE OF FACILITY REPORTING
Please check one of the following:
PUBLIC SCHOOL ____ PRIVATE SCHOOL ____ PAROCHIAL SCHOOL ____ HEAD START ____ CHILD CARE CENTER ____

INSTRUCTIONS
(1) Please complete this report using information in each student’s school medical record.
(2) Please refer to the back section of this form for the MINIMUM IMMUNIZATIONS REQUIRED BY THE
CODE OF VIRGINIA
(3) ALL SCHOOLS Please submit to the ADDRESS BELOW by
VIRGINIA DEPARTMENT OF HEALTH
BUREAU OF IMMUNIZATION
1500 E. MAIN STREET, SUITE 120
RICHMOND, VIRGINIA 23219
PHONE (804) 786-6246

COMPLETE THE SECTION(S) APPLICABLE TO YOUR FACILITY
Please note in each section, numbers in columns (b) through (f) should add together to
equal the total number of students in column(s).

SECTION I
CHILD CARE CENTERS, HEAD STARTS OR PRESCHOOLS

<table>
<thead>
<tr>
<th>(a)</th>
<th>(b)</th>
<th>(c)</th>
<th>(d)</th>
<th>(e)</th>
<th>(f)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Student Enrolled</td>
<td>Number Adequately Immunized</td>
<td>Number of Medical Exemption</td>
<td>Number of Religious Exemptions</td>
<td>Number Conditionally Enrolled</td>
<td>Number Without Records</td>
</tr>
</tbody>
</table>

SECTION II
KINDERGARTEN OR FIRST GRADE IF THERE IS NO KINDERGARTEN (PUBLIC, PRIVATE, PAROCHIAL)

<table>
<thead>
<tr>
<th>(a)</th>
<th>(b)</th>
<th>(c)</th>
<th>(d)</th>
<th>(e)</th>
<th>(f)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Students Enrolled</td>
<td>Number Adequately Immunized</td>
<td>Number of Medical Exemptions</td>
<td>Number of Religious Exemptions</td>
<td>Number Conditionally Enrolled</td>
<td>Number Without Records</td>
</tr>
</tbody>
</table>
MINIMUM IMMUNIZATIONS REQUIRED OF NEW STUDENTS BY THE
STATE BOARD OF HEALTH FOR SCHOOL ATTENDANCE

For more information, please refer to the Code of Virginia 22.1-271, Immunization Requirements and Section 3.00 of the Rules and Regulations for the Immunization of School Children.

**DTP**: THREE (3) doses of DTP with one (1) administered after the fourth birthday. If any of these doses must be administered on or after the seventh birthday, ADULT Td vaccine should be used instead of DTP.

**OPV**: THREE (3) doses of trivalent OPV or THREE (3) doses IPV (when OPV is medically contraindicated) with one administered after the fourth birthday.

**MEASLES**: TWO (2) doses of live virus measles (rubeola) vaccine, one (1) dose given at 12 months of age or older and a second dose administered prior to entering KINDERGARTEN or first grade, whichever occurs first, effective JULY 1, 1991. Two (2) doses of live measles vaccine shall also be required of students enrolling in grade six (6) in 1992 and thereafter. All other students should have received on (1) dose of live measles vaccine.

**RUBELLA**: ONE (1) dose of rubella vaccine received at 12 months of age or older.

**MUMPS**: ONE (1) dose of mumps vaccine received at 12 months of age or older for students entering school on or after August 1, 1981.

**HEPATITIS B**: For children born on or after January 1, 1994, three (3) doses of hepatitis B vaccine.

**HAEMOPHILUS INFLUENZAE TYPE b (Hib)**: For children through 30 months of age, Hib conjugate vaccine should be administered as recommended by the American Academy of Pediatrics or the U.S. Public Health Service.

**CONDITIONAL ENROLLMENT**: In order for a student to be CONDITIONALLY ENROLLED, the student must have proof of having received at least one (1) dose of each of the required immunizations (DTP, OPV, MEASLES, MUMPS, and RUBELLA) and have a schedule on file to receive the remainder of the required doses within 90 DAYS.

**RELIGIOUS EXEMPTIONS**: The student or his parent or guardian submits a CERTIFICATE OF RELIGIOUS EXEMPTION (FORM CRE-I), to the admitting official of the school to which the student is seeking admission. Form CRE-I is an affidavit stating that the administration of immunizing agents conflicts with the student’s religious tenets or practices. The CRE-I must be signed by a NOTARY PUBLIC AND STAMPED WITH THE NOTARY’S SEAL.

**MEDICAL EXEMPTIONS**: The school must have written certification from a physician or a local health department on FORM MCH213C that one or more of the required immunizations may be detrimental to the
student’s health. Such certification of medical exemption shall specify the nature and probable duration of the medical condition or circumstance that contraindicates immunization.

If there are questions regarding immunizations please call your local health department or the Bureau of Immunization at (804) 786-6246.
[Note. This form was replaced by MCH 213C, Rev. 10/91, effective 2/5/99.]

Form HPE-n12 12/83

SCHOOL ENTRANCE HEALTH INFORMATION FORM

Name: ___________________________ Birthdate: Mo. ______ Day ______ Yr. ______

Last First Middle Name

Sex: Male ______ Female ______ Race: ______ Child’s Social Security Number: ______

Parent or Guardian: ___________________________ Work Phone: ___________________________

Last First Middle Initial

Home Address: ___________________________ Home Phone: ___________________________

Zip: ______ Person to call in case of an emergency if parent/guardian is not available:

Name: ___________________________ Phone: ___________________________

Please provide information relative to the general health of your child entering school for the first time
and return to principal within 15 days.

ACUTE OR CHRONIC ILLNESS

_____ Yes ______ No Asthma

_____ Yes ______ No Cerebral Palsy

_____ Yes ______ No Cystic Fibrosis

_____ Yes ______ No Diabetic (Insulin dependent)

_____ Yes ______ No Epilepsy

_____ Yes ______ No Frequent colds

_____ Yes ______ No Frequent sore throat

_____ Yes ______ No Hyperthyroidism

_____ Yes ______ No Hypothyroidism

_____ Yes ______ No Allergies other than those related to foods/drugs: if yes, describe

__________________________

_____ Yes ______ No Cancer: if yes, describe

__________________________

_____ Yes ______ No Heart disease: if yes, describe

__________________________

ACCIDENTS

Has your child had any of the following? If yes, describe

_____ Yes ______ No Burns requiring treatment

__________________________

_____ Yes ______ No Bumps to head requiring treatment

__________________________

_____ Yes ______ No Fractures

__________________________

_____ Yes ______ No Lacerations or cuts requiring stitches or tetanus booster

__________________________

_____ Yes ______ No Near drowning

__________________________

_____ Yes ______ No Poisoning

__________________________

_____ Yes ______ No Serious falls

__________________________

MEDICATIONS

Is your child using any medicines? If yes, describe

_____ Yes ______ No Prescription drugs: identify drug and condition requiring drug

__________________________

_____ Yes ______ No Over-the-counter drugs (nonprescription): identify drug and reason for use

__________________________

_____ Yes ______ No Drug allergies: identify drug and reaction

__________________________
NUTRITION
- Yes  No  Abdominal pain
- Yes  No  Underweight or overweight for age
- Yes  No  Allergies related to foods: identify food and reaction
- Yes  No  Problems with elimination (bowel movement and/or urination)

OPERATIONS
- Yes  No  Appendectomy
- Yes  No  Hema
- Yes  No  Tonsillectomy
  Other

HANDICAPPING CONDITION
- Yes  No  Scoliosis
- Yes  No  Spina bifida
  Other

ORTHOPEDIC DEVICES
- Yes  No  Wheelchair
- Yes  No  Special shoes
- Yes  No  Crutches
- Yes  No  Braces
- Yes  No  Headset

BLOOD DISORDERS
- Yes  No  Anemia
- Yes  No  Leukemia
- Yes  No  Hemophilia
- Yes  No  Sickle Cell Anemia

HEARING
- Yes  No  Frequent earaches
- Yes  No  Running ear
- Yes  No  Hard of hearing
- Yes  No  Uses hearing aid

BLOOD DISORDERS
- Yes  No  Sleeps/Rests well
- Yes  No  Exercises daily
- Yes  No  Eats well
- Yes  No  Baths regularly
- Yes  No  Brushes teeth regularly

COMMUNICATION
- Yes  No  Speech understandable
- Yes  No  Stuttering/stammers
- Yes  No  Lips

VISION
- Yes  No  Wears glasses
- Yes  No  Rubs eyes frequently
- Yes  No  Squint
- Yes  No  Color blind

DENTAL
- Yes  No  Cavities
- Yes  No  Cleft lip or palate
- Yes  No  Gum disease
- Yes  No  Lost some or all baby teeth
- Yes  No  Permanent teeth appearing
- Yes  No  Wears dental braces

SKIN AND HAIR
- Yes  No  Visible scars
- Yes  No  Hives
- Yes  No  Scabies
- Yes  No  Body lice
- Yes  No  Head lice

MENTAL AND EMOTIONAL
- Yes  No  Bullies others
- Yes  No  Cries often
- Yes  No  Lethargic (slow/lazy)
- Yes  No  Short attention span
- Yes  No  Toilet trained
- Yes  No  Very sensitive
- Yes  No  Very shy
- Yes  No  Generally happy

Were there any prenatal or birth complications which affected the child?

Please indicate any other health condition(s) your child has that is not covered on form.

Signed:  
(Signature by parent/guardian)

Date:  

VIRGINIA HIGH SCHOOL LEAGUE, INC.
1942 State Farm Blvd., Charlottesville, Va. 22911

Athletic Participation/Parental Consent/Physical Examination Form

Part 1 - ATHLETIC PARTICIPATION

Name: ____________________________ Social Security #: ________________

Last: ____________________________ First: ____________________________
Middle: __________________________

Home Address: __________________________
City/Zip Code: __________________________
City/Zip Code: __________________________
Home Address of Parents: __________________________
City/Zip Code: __________________________
Date of Birth: __________________________
Place of Birth: __________________________

This is my ______ semester in ______ High School, and my ______ semester since first entering the ninth grade. Last semester I attended ______ School and passed ______ credit subjects, and I am taking ______ credit subjects this semester. I have read the condensed individual eligibility rules and risk statement of the Virginia High School League that appear below and believe I am eligible to represent my present high school in athletics.

INDIVIDUAL ELIGIBILITY RULES

Attention athletes (includes cheerleaders)! To be eligible to represent your school in any VHSL Interscholastic athletic contest, you:

♦ must be a regular bona fide student in good standing of the school you represent.
♦ must be enrolled in the last 4 years of high school. (Eighth-grade students may be eligible for junior varsity competition.)
♦ must have enrolled not later than the fifteenth day of the current semester.
♦ must have passed at least five credit subjects the immediately preceding year and must be currently taking not fewer than five credit subjects for participation during the first semester.
♦ must have passed at least five credit subjects in the previous semester and must be currently taking not fewer than five credit subjects for participation during the second semester.
♦ must not have reached your nineteenth birthday on or before the first day of August of the current school year.
♦ must have been in residence at your present high school or at a junior high school from which your high school receives its students during the entire semester immediately preceding the one in which you wish to participate.
♦ must not, after entering the ninth grade for the first time, have been enrolled in or been eligible for enrollment in high school more than eight consecutive semesters. [This rule also applies to a student who becomes "ungraded" for failure to earn a Literacy Passport. For this student, the eight consecutive semesters shall be counted continuously beginning with his/her first semester in the ninth grade or the first semester in which he/she become classified as "ungraded," whichever comes first.]
♦ must have submitted to your principal before any kind of participation, including tryouts or practice as a member of any school athletic or cheerleading team, an Athletic Participation/Parental Consent/Physical Examination Form, completely filled in and properly signed attesting that you have been examined during this school year and found to be physically fit for athletic competition and that your parents consent to your participation.
♦ must be an amateur as defined by the Virginia High School League: "An amateur is an athlete who engages in VHSL athletics solely for the educational, physical, mental, and social benefits he derives therefrom and to whom VHSL athletics are nothing more than an avocation."
♦ must not have received in recognition of your ability as a high school athlete any award not presented or approved by your school or the League."
♦ must not be in violation of the VHSL all-star rule."
♦ must not have been a member of a college team in the sport in which you wish to participate."

Italics or underlining in icase do not apply to cheerleaders.

Eligibility to participate in Interscholastic athletics is a privilege you earn by meeting not only the above-listed minimum standards, but also all other standards set by your League, district, and school. If you have any question regarding your eligibility or are in doubt about the effect an activity might have on your eligibility, check with your principal or athletic director for interpretations and exceptions provided under League rules. Meeting the intent and spirit of League standards will prevent you, your team, school, and community from being penalized.

LOCAL SCHOOL DIVISIONS AND VHSL DISTRICTS MAY REQUIRE ADDITIONAL STANDARDS TO THOSE LISTED ABOVE.

Student Signature: __________________________
Date: __________________________

Providing false information will result in ineligibility for one year.
## PART II - MEDICAL HISTORY

This form should be completed by parent and schhste prior to time of the physical examination and should be taken with physical examination form for review by the physician during the examination.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>1. Have you ever had any of the following? Please explain any YES answers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>heart murmur</td>
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<td></td>
<td></td>
<td>high blood pressure</td>
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<td></td>
<td></td>
<td>other heart problems</td>
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<td></td>
<td></td>
<td>broken bones</td>
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<td></td>
<td></td>
<td>weak joints - ankles, knees</td>
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<td></td>
<td></td>
<td>constipation</td>
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<td></td>
<td></td>
<td>operation</td>
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<td></td>
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<td>seizures or epilepsy</td>
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<td>2. Have you ever fainted or passed out?</td>
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<td>3. Have you ever been knocked out?</td>
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<td>4. Have you ever been hospitalized?</td>
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<td>5. Have you ever had to stop running after ¼ to ¼ miles for chest pain or shortness of breath?</td>
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<td>6. A. Have you ever had significant allergies to:</td>
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<td></td>
<td></td>
<td>bee stings - On medication- yes__no__</td>
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<td>foods</td>
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<td></td>
<td></td>
<td>medicine</td>
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<td></td>
<td></td>
<td>others</td>
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<td>B. Do you have prescription for use of:</td>
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<td></td>
<td></td>
<td>Adrenaline</td>
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<td></td>
<td></td>
<td>Inhalers</td>
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<td>Other allergy medicine</td>
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<td>C. Do you have asthma?</td>
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<td>7. Do you take any medicine regularly?</td>
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<td>8. Have you any illnesses lasting a week or more such as mononucleosis, etc.?</td>
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<td>9. Have you had any blood disorders, including skidle cell trait, anemia, etc.?</td>
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<td>10. Has any family member had a heart attack, heart problems or sudden death before the age of 50?</td>
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<td>11. Do you wear contact lenses, eyeglasses or dental appliance?</td>
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<td>12. Do you have any missing or non-functioning organs such as testes, eye, kidney, etc.?</td>
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<td>13. Menstrual History:</td>
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<td>Have you begun menstes yet?</td>
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<td>14. Do you have any other significant health problems?</td>
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<td>15. DATE OF LAST TETANUS IMMUNIZATION?</td>
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</tbody>
</table>
PART III - PHYSICAL EXAMINATION

[Editorial note: This form must be completed and signed by an attending physician.)

NAME: ____________________________ SCHOOL: ____________________________

HEIGHT: ____________________________ WEIGHT: ____________________________ SEX: ________ AGE: ________ GRADE: ________

*Tanner Stage of Pubescence Index: ____________________________

*Percentile (Fat): ____________________________

BP: ____________________________

*Pulse (rest): ____________________________

(Exercising) ____________________________

(Recovery) ____________________________

*Vision: Corrected (L) ________ (R) ________ Both ________

Uncorrected (L) ________ (R) ________ Both ________

*Audiogram: ____________________________

Cervical spine/neck: ____________________________

Back: ____________________________

Shoulders: ____________________________

Arm/elbow/wrist/hand: ____________________________

Knees/hips: ____________________________

Ankles/feet: ____________________________

Skin: ____________________________

Lymphatics: ____________________________

Lungs: ____________________________

Heart: ____________________________

Abdomen: ____________________________

Genitalia/hemias: ____________________________

Peripheral pulses: ____________________________

*WHEN MEDICALLY INDICATED

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics:

Full Participation ________ Limited Participation ________ No Participation ________ Needs Additional Evaluation ________

If not full participation give reasons & recommendations:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Any recommendations or concerns on such items as:

a. Weight loss or gain or restrictions of weight loss:

b. Slow and careful monitoring of conditioning because of being overweight or show an abnormal exercise testing:

c. Other:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Physician Signature: ____________________________ M.D. * Date: ____________________________

Physician Name (print): ____________________________

Address: ____________________________

City/Zip Code: ____________________________

Telephone Number: ____________________________

*Doctor of Medicine, Doctor of Osteopathy or Licensed Nurse Practitioner
PART IV - ACKNOWLEDGEMENT OF RISK AND INSURANCE STATEMENT

(To be completed and signed by parent/guardian)

I give permission for ______________________ to participate in any of the following sports that are _____________________________________________________________________________________________

not crossed out: baseball, basketball, cheerleading, cross country, field hockey, football, golf, gymnastics, lacrosse, soccer, softball, swimming/diving, tennis, track, volleyball, wrestling, other (identify sports) _____________________________________________________________________________________________

I have reviewed the individual eligibility rules and I am aware that with the participation in sports comes the risk of injury to my child/ward. I understand that the degree of danger and the seriousness of the risk varies significantly from one sport to another with contact sports carrying the higher risk. I have had an opportunity to understand the risk inherent in sports through meetings, written handouts, or some other means. He/She has student accident insurance available through the school (yes___ no___); has football insurance coverage through the school (yes___ no___); is insured by our family policy with:

___________________________________________________________________________________________

(Name of Company)

Policy Number________________________ Name of Insured________________________

I am aware that participating in sports will involve travel with the team. I acknowledge and accept the risks inherent in the sport and with the travel involved and with this knowledge in mind, grant permission for my child/ward to participate in the sport and travel with the team.

I also give my consent and approval for my child/ward to receive a physical examination, as required in Part IV, Physical Examination, of this form, by _______________________________ M.D., O.D. or LNP as recommended by the named student's school administration.

Additionally I give my consent and approval for the above named student's picture and name to be printed in any high school or VHSL athletic program.

Signature of parent/guardian_________________________________________________________ Date________________________

PART V - EMERGENCY PERMISSION FORM*

(To be completed and signed by parent/guardian)

STUDENT'S NAME________________ GRADE____ AGE________

HIGH SCHOOL_______________ CITY________________________

EMERGENCY AUTHORIZATION: In the event I cannot be reached in an emergency, I hereby give permission to physicians selected by the coaches and staff of __________________________ High School to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for the person named above.

Daytime phone number (where to reach you in emergency)________________________

Evening time phone number (where to reach you in emergency)________________________

Signature of parent or guardian________________________________________________ Date________________________

Relationship to student_________________________________________________________________________

*Emergency Permission Form may be reproduced to travel with respective teams and is acceptable for emergency treatment if needed.

Revised June, 1998
### CUMULATIVE HEALTH RECORD

**ANNUAL PHYSICAL INSPECTION**

**FULL NAME**  
**LAST**  
**FIRST**  
**MIDDLE**  
**DATE OF BIRTH**  

**SEX**  
- SCARLET FEVER ( )  
- SMALL POX ( )  
- PERTUSSIS (WHOOPING COUGH) ( )  
- CHICKEN POX ( )  
- MUMPS ( )  
- MEASLES ( )  

**CHECK DISEASES HAD ( )**  
- RHEUMATIC FEVER ( )  
- DIPHTHERIA ( )

**CODE: NO DEFECT ( )**

<table>
<thead>
<tr>
<th>YEAR</th>
<th>DEFECTION</th>
<th>DEFECT CORRECTED ( )</th>
<th>DEFECT BEING TREATED ( )</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**HEIGHT**

**WEIGHT**

**VISION RIGHT**

**VISION LEFT**

**HEARING RIGHT**

**HEARING LEFT**

**TEETH**

**THROAT**

**SCOLIOSIS**

**POSTURE**

**SPEECH**

**PARENTS/GUARDIAN NOTIFIED ( )**

**EXAM (BY PHYSICIAN) ( )**

**EXAM (BY DENTIST) ( )**

**IMMUNIZATION HISTORY**

**REMARKS**

(When no medical examination is given, leave space blank)
<table>
<thead>
<tr>
<th>YEAR</th>
<th>RECOMMENDATIONS BY PHYSICIAN OR DENTIST</th>
<th>NAME OF PHYSICIAN OR DENTIST</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td></td>
<td>Physician</td>
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<td>Dentist</td>
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<td>Physician</td>
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<td>Physician</td>
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<td>Dentist</td>
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</table>
COMMONWEALTH OF VIRGINIA
Summary of Screening of Vision and Hearing
Report to Principal

School: ___________________________  Year: ___________________________

Person Preparing Data: ___________________________  Signature: ___________________________

Principal or Designee

Check Level:  
___ Elementary  (Grade 3)  Total student population: ___________________________
___ Secondary  (Grade 7)  Total student population: ___________________________
___ Secondary  (Grade 10)  Total student population: ___________________________

<table>
<thead>
<tr>
<th>SCREENING</th>
<th># SCREENED</th>
<th>NUMBER REFERRED FOR SUSPECTED DEFECT</th>
<th>NO REPORT FOLLOWING REFERRAL</th>
<th>NUMBER OF THOSE REFERRED THAT WERE SEEN BY HEALTH CARE PROVIDERS</th>
<th>NUMBER OF THOSE SEEN WITH CONDITION DIAGNOSED BY HEALTH CARE PROVIDER (Includes those seen once as well as those receiving ongoing active care)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>BOY  GIRL  TOTAL</td>
<td>BOY  GIRL  TOTAL</td>
<td>BOY  GIRL  TOTAL</td>
<td>BOY  GIRL  TOTAL</td>
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<tr>
<td>VISION</td>
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<td>HEARING</td>
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</tbody>
</table>

* Screener should submit separate summaries for each designated grade level.

LF.011
SUMMARY OF SCREENING OF VISION AND HEARING

School: Self explanatory

Year: School year - example: 1991-92

Person Preparing Data: The name and title of person who is collecting data.
Example: Mary Smith, RN, or Julia Brown, Teacher

Signature of Principal: Self Explanatory

Check Level: Check appropriate grade level.

Total Student Population: Total number of students in grade level checked above

Number Screened: Total number screened

Number Referred for Suspected Defect: (reported by gender and total) This is the number of suspected defects out of the total number screened.

No Report Following Referral: (reported by gender and total) This equals all those referred that no report or follow-up has been done.

Number of Those Referred That Were Seen By Health Care Providers:

This reflects those who were seen by an ophthalmologist, physician, optometrist or other health care provider for the suspected defect.

Number of Those Seen With Condition Diagnosed by Health Care Provider:

(reporting by gender) This includes those seen once as well as those who may continue to receive ongoing care. This number reflects those with corrections even though it may take several visits or years to complete care. Once the child is under care for condition, the primary goal has been met.

Submit to Superintendent or Designee for compilation of the local school division's cumulative report.

L.F..011
3/95
<table>
<thead>
<tr>
<th>School Division:</th>
<th>Person Preparing Data:</th>
<th>Year:</th>
</tr>
</thead>
<tbody>
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</table>

### Summary of Screening of Vision and Hearing

<table>
<thead>
<tr>
<th>Screening</th>
<th>No Report Following Referral</th>
<th>Number of Those Seen with Condition Diagnosed by Health Care Provider (Includes those seen once as well as those receiving ongoing active care)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>VISION</td>
<td></td>
<td></td>
<td>BOY</td>
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<tr>
<td>HEARING</td>
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<td></td>
<td>GIRL</td>
</tr>
</tbody>
</table>

**Note:** Filed locally for administrative purposes.

LF/010 3/05
COMMONWEALTH OF VIRGINIA
DEPARTMENT OF EDUCATION
SCOLIOSIS REPORT

SCHOOL DIVISION: _______________________________ DATE _______________________________

NAME OF SCHOOL: ________________________________________________________________

PERSON COMPLETING FORM: _______________________________________________________

TITLE OR POSITION: ________________________________________________________________

RESULTS OF MEDICAL EXAMINATION OF REFERRED STUDENTS FROM THIS YEAR'S
SCREENING PROGRAM.

<table>
<thead>
<tr>
<th>GRADE LEVEL AND SEX</th>
<th>NUMBER SCREENED</th>
<th>NUMBER SCREENED WITH SUSPECTED FINDINGS AND REFERRED FOR FURTHER SCREENING</th>
<th>NUMBER SCREENED WITH SIGNIFICANT FINDINGS</th>
<th>RESULTS OF MEDICAL EXAMINATION OF REFERRED STUDENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CASES DIAGNOSED</td>
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<tr>
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<td></td>
<td></td>
<td>NO TREATMENT</td>
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<td></td>
<td></td>
<td>RECOMMENDED TREATMENT (BRACING, EXERCISE, AND/OR</td>
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<td></td>
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<td></td>
<td>PHYSICIAN PRESCRIPTION)</td>
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<td>SURGERY</td>
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<td></td>
<td>OTHER CONDITIONS (DIAGNOSES OTHER THAN SCOLIOSIS</td>
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<td></td>
<td>IDENTIFIED AT THIS TIME)</td>
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<td></td>
<td>NO RESPONSE TO REFERRAL</td>
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</tbody>
</table>

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| 5 M |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 5 F |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 6 M |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 6 F |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 7 M |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 7 F |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 8 M |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 8 F |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 9 M |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 9 F |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| TOTAL|    |    |    |    |    |    |    |    |    |    |    |    |    |    |

Numbers in columns 7, 8, 9, 10, and 11 should equal number in column 6.
Numbers in columns 5, 6, and 12 should equal the number in column 4.
| Column 2 | The number in this column does not include those students having had surgery, braces, or undergoing treatment at this time. These should be included in column 13. |
| Column 3 | The number in this column are students with suspected findings and referred to a physician during this year. A student may be counted who was referred last year and did not receive treatment and was screened again this year and referred again. This includes those students whose physicians recommended no treatment last year but requested continued monitoring. |
| Column 6 | The number in this column includes all the students diagnosed as having scoliosis after being referred from column 3. |
| Column 12 | The number in this column includes all the students who have postural conditions and diagnosed as a condition other than scoliosis by the physician. List these conditions below: |
| \[ \text{List of conditions} \] |
| Column 13 | No student in this column should have been included in any other column on this report. |
| \[ \text{List of conditions} \] |

Please compile and return to designated person within local school division.

Disposition: To be maintained and filed locally.