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).
- Summary of Screening of Vision and Hearing: School Division Report (LF.010, 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, I.

Student's Name: _____ (Last / First / Middle)
Student's Date of Birth: |__|__|__|__| (Mo. Day Yr) 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: |__|__|__| - |__|__|__| - |__|__|__|__| (Area Code) Work Phone: |__|__|__| - |__|__|__| - |__|__|__|__| (Area Code)
Name of Father or Legal Guardian: _____
Home Phone: |__|__|__| - |__|__|__| - |__|__|__|__| (Area Code) Work Phone: |__|__|__| - |__|__|__| - |__|__|__|__| (Area Code)
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): _____

Equipment Used and Specialized Health Care Needed *(Check all that apply and explain below. *)*		**Chronic, Recurring, and Special Health Conditions** *(Check all that apply and explain below. *)*
Equipment Used by Child:	**Catheterization**	Arthritis (rheumatoid)
Glasses / Contact Lens	Clean Intermittent Catheterization	Asthma
Hearing Aid	External Catheter	Attention-Deficit/Hyperactivity Disorder
Helmet	Other:	Behavioral or Developmental Problems
Wheelchair / Walker	**Medical Support Systems**	Cerebral Palsy
Other:	Hickman / Broviac / IVAC/ IMED	Cystic Fibrosis
	Mechanical Ventilator	Dental Problems
	Oxygen	Diabetes
Specialized Health Care Needed:	Ventricular Peritoneal Shunt	Encopresis (involuntary discharge of stool)
Activities of Daily Living	Other:	Enuresis (involuntary discharge of urine)
Bowel / Bladder Training	**Ostomies**	Head or Spinal Injury
Diapering / Toileting	Ostomy Care	Hearing Impairment
Lifting / Positioning	Other	Heart Disease
Other:	**Respiratory Assistance**	Kidney Disease
Feeding	Percussion	Muscular Dystrophy
Gastrostomy Feeding	Postural Drainage	Seizures
Jejunostomy Tube Feeding	Suctioning	Sickle Cell Disease (not trait)
Naso-Gastric Feeding	Other:	Spina Bifida
Oral Feeding	**Specimen Collecting / Testing**	Visual Impairment
Total Parenteral Feeding	Blood Glucose	Other:
Other:	Other:	

*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., anemia, 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: _____ (Last) _____ (First) _____ (Middle)

Date of Birth: |__|__|__| (Mo. Day Yr.) 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: |__|__|__| (Mo. Day Yr.)

If performed, date of most recent blood lead level: |__|__|__| (Mo. Day Yr.) Results: _____ µg/dL

Vision Screening

Distance visual acuity screening results, without corrrection: 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 referrred? Yes |__|, No |__|

Hearing

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 |__|

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

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

PART III - CERTIFICATION OF IMMUNIZATION

Part III to be completed by a physician or health department official.

Student's Name: _____ Date of Birth: |__|__|__|__|
Last *First* *Middle* *Mo. Day Yr.*

Student's Social Security #: |__|__|__| - |__|__| - |__|__|__|__| or I.D. #: _____

Name of Parent/Guardian: _____

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
Poliomyelitis (OPV or IPV)	1	2	3	4	5
Haemophilus influenzae Type b (Hib Conjugate Vaccine)	1	2	3	4	
Measles (Rubeola)	1	2	Serological Confirmation of Measles Immunity :		
Rubella	1	2	Serological Confirmation of Rubella Immunity :		
Mumps	1	2	Other (List type and date received):		
Measles, Mumps, Rubella (MMR vaccine)	1	2			
Hepatitis B Vaccine (HBV)	1	2	3	Other:	
Varicella Vaccine	1	2	Other:	Other:	
Rotavirus Vaccine	1	2	3	Other:	

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:[___]; DT/Td:[___]; 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: _____ **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).

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: _____ **Date (*Mo., Day, Yr.*):**|__|__|__|

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: _____ **Date (*Mo., Day, Yr.*):**|__|__|__|

MCH-213 D, PART III, REV. 1/99

[**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:_____
LAST FIRST MI

Complete Date of Birth:(___/___/___); Sex:(___); Number of Children in Family(___); State or Country of Birth:_____
MO DAY YR.

Social Security #:(___/___/___/___/___/___/___/___/___); I.D. #:_____

Parent or Legal Guardian:_____

Address:_____;City:_____;Zip:(___/___/___/___/___/

Home Phone:(_____)--_____--_____; Work Phone:(_____)--_____--_____
area code area code

School's Name:_____; Grade:(___/
In case of emergency, notify: (other than parent or guardian) Please list Name, address, and Complete Phone Number (area code and number).

1)_____ Phone:(_____) _____-_____
area code

2)_____ Phone:(_____) _____-_____
area code

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

Allergies to food, medicine, insect bites/stings, 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)
	Prosthesis (e.g., cane, crutch, limb)		Ear Infections
	Brace		Hard of Hearing
	Hearing Aids		Seizures/spells
	Glasses		Kidney Disease
	Helmet		Sickle Cell Anemia (not trait)
	Wheelchair or Walker		Head, spinal cord injury, or disease of central nervous system
	Special Shoes		Eye Diseases
	Other (Please List!):		Heart Disease
			Asthma
			Diabetes
			Other (Please List!):

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 (mo,day,yr):(___/___/___/

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: _____ (LAST / FIRST / MI); Birth Date: ____/____/____ (MO / DAY / YR)

Height: _____; Weight: _____; Head Circumference: _____; BP: _____

Hemoglobin or Hematocrit: _____ gm%; Urine Albumin: _____; Sugar: _____; Other: _____

Most recent Tuberculin Test Date: ____/____/____ (Mo / Day / Yr); Results: _____; Hearing R _____; L _____

Vision (w/out glasses) R20/_____; L20/_____; Hearing test performed? Audiogram _____; Voice _____

Vision (with glasses) R20/_____; L20/_____; Tympanogram (if indicated): normal _____; abnormal _____

Systems Examination	Exam.	Not Exam.	Comments About Findings
General Appearance, Nutrition			
Posture, Gait			
Skin			
Head			
Eyes: External			
Fundi			
Ears: External & Canal			
Tympanic Membrane			
Nose			
Throat			
Teeth			
Neck			
Heart			
Lungs			
Abdomen			
Genitalia (Tanner Stage)			
Bones, joints, muscles			
Neurological			
Other:			
Est. of developmental level			
Behavioral Observations:			
Cooperation			
Emotional tone			
Activity level			

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: (_____) _____ – _____ (area code)

MCH-213C,Rev.10/91

PART III ***CERTIFICATION OF IMMUNIZATION***

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

Student's Name:_____ **DOB:**__/__/__
LAST FIRST MI MO DAY YR

Student's S.S. #:_____; **I.D #:**_____

Parent/Guardian:_____

IMMUNIZATIONS	RECORD COMPLETE DATES (month,day,year) OF VACCINE DOSES ADMINISTERED				
Diphtheria/Tetanus/Pertussis (DTP)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Diphtheria/Tetanus (DT or Adult Td)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Poliomyelitis (OPV or eIPV)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Measles (Rubeola)	__/__/__	__/__/__	Serological Confirmation of Measles Immunity	__/__/__	
Rubella	__/__/__	__/__/__	Serological Confirmation of Rubella Immunity	__/__/__	
Mumps	__/__/__	__/__/__	Child Entered School Before 08/01/81	__/__/__	
Measles, Mumps, Rubella (MMR)	__/__/__	__/__/__			
Hepatitis B Vaccine	__/__/__	__/__/__	__/__/__	Other:_____	__/__/__

Haemophilus 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:__/__/__
MO DAY YR

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

__/ *Being over 30 months of age, this child is not required by law to have proof of immunization against Hib.*

MEDICAL EXEMPTION: DTP__/; Td__/; OPV__/; Hib__/; Measles__/; Mumps__/; Rubella__/.
As specified in 22.1-271.2,c(ii) 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:__/__/__

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 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 22.1-271.2, C(i), 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(mo,day,yr):*__/__/__

**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.

S.S #:_____

IMMUNIZATION RECORD

VIRGINIA DEPARTMENT OF HEALTH

Name:_____ **DOB:**_____

	DATE	DATE	DATE	DATE	DATE
Diphtheria/Tetanus/ Pertussis (DTP)	____	____	____	____	____
Diphtheria/Tetanus (DT or Adult Td)	____	____	____	____	____
Poliomyelitis (OPV or eIPV)	____	____	____	____	____
Measles (Rubeola)	____	____	____	____	____
Rubella	____	____	____	____	____
Mumps	____	____	____	____	____
Measles, Mumps, Rubella (MMR)	____	____	____	____	____
Hepatitis B Vaccine	____	____	____	____	____
Haemophilus Influenza type b (Hib)	____	____	____	____	____

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 are either dates of vaccinations given or dates recorded with the Virginia Department of Health by the Patient.

_____ _____

Public Health Official Date

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

(a) Number of Student Enrolled	(b) Number Adequately Immunized	© Number of Medical Exemption	(d) Number of Religious Exemptions	(e) Number of Conditionally Enrolled	(f) Number Without Records

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

(a) Number of Students Enrolled	(b) Number Adequately Immunized	© Number of Medical Exemptions	(d) Number of Religious Exemptions	(e) Number Conditionally Enrolled	(f) Number Without Records

Form SIS-2, Rev. 4/99

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.

REI.IGIOUS EXEMPTIONS: The student or his parent or guardian submits a CERTIFICATE OF REI.IGIOUS 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-1 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-h12 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 Phone: _____

Home Address: _____ 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 food/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 Hernia
__ 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 Helmet

HEARING

__ Yes __ No Frequent ear aches
__ Yes __ No Running ear
__ Yes __ No Hard of hearing
__ Yes __ No Uses hearing aid

COMMUNICATION

__ Yes __ No Speech understandable
__ Yes __ No Stutters/stammers
__ Yes __ No Lisps

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

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

BLOOD DISORDERS

__ Yes __ No Anemia
__ Yes __ No Leukemia
__ Yes __ No Hemophilia
__ Yes __ No Sickle Cell Anemia

HABITS

__ Yes __ No Sleeps/Rests well
__ Yes __ No Exercises daily
__ Yes __ No Eats well
__ Yes __ No Bathes regularly
__ Yes __ No Brushes teeth regularly.

VISION

__ Yes __ No Wears glasses
__ Yes __ No Rubs eyes frequently
__ Yes __ No Squints
__ Yes __ No Color blind

SKIN AND HAIR

__ Yes __ No Visible scars
__ Yes __ No Hives
__ Yes __ No Scabies
__ Yes __ No Body lice
__ Yes __ No Head lice

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

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

Signed:
(Signature by parent/guardian)

Date:

VIRGINIA HIGH SCHOOL LEAGUE, INC.
1642 State Farm Blvd., Charlottesville, Va. 22911

Athletic Participation/Parental Consent/Physical Examination Form

Separate examination and certification required for each school year. May 1 of the current year through June 30 of the succeeding year. File in the Office of the Principal.

For School Year_____

Part 1 - ATHLETIC PARTICIPATION
(To be filled in and signed by the student)

Male_____
Female_____

Name_____ Social Security #_____
(Last) (First) (Middle Initial)

Home Address_____

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 athlete (includes cheerleader)! 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 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.**

***Italicized item does 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.

_____ Date:_____
Student Signature

Providing false information will result in ineligibility for one year.

PART II – MEDICAL HISTORY

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

YES	NO		
		1.	Have you ever had any of the following? Please explain any YES answers
___	___		heart murmur_____
___	___		high blood pressure_____
___	___		other heart problems_____
___	___		broken bones_____
___	___		weak joints - ankles, knees_____
___	___		concussion_____
___	___		operation_____
___	___		seizures or epilepsy_____
___	___	2.	Have you ever fainted or passed out?_____
___	___	3.	Have you ever been knocked out?_____
___	___	4.	Have you ever been hospitalized?_____
___	___	5.	Have you ever had to stop running after ¼ to ½ miles for chest pain or shortness of breath?_____
		6.	A. Have you ever had significant allergies to:
___	___		bee stings - On medication- yes___no__ _____
___	___		foods_____
___	___		medicine_____
___	___		others_____
			B. Do you have prescription for use of:
___	___		Adrenalin_____
___	___		Inhalers_____
___	___		Other allergy medicine_____
___	___		C: Do you have asthma?_____
___	___	7.	Do you take any medicine regularly?_____
___	___	8.	Have you any illnesses lasting a week or more such as mononucleosis, etc?_____
___	___	9.	Have you had any blood disorders, including sickle cell trait, anemia, etc.?_____
___	___	10.	Has any family member had a heart attack, heart problems or sudden death before the age of 50?_____
___	___	11.	Do you wear contact lenses, eyeglasses or dental appliance?_____
___	___	12.	Do you have any missing or non-functioning organs such as testes, eye, kidney, etc.?_____
		13.	Menstrual History:
___	___		Have you begun menses yet? _____
___	___	14.	Do you have any other significant health problems? _____
		15.	DATE OF LAST TETANUS IMMUNIZATION? _____

PART III – PHYSICAL EXAMINATION

(To be completed and signed by examining physician)

NAME_____ SCHOOL_____

HEIGHT_____ WEIGHT_____ SEX_____ AGE_____ GRADE_____

*Tanner Stage or Maturation Index_____

*Percentage Body Fat_____

BP _____

*Pulse (rest) _____

(Exercise) _____

(Recovery) _____

*Vision: Corrected (L)___(R)___Both___

Uncorrected (L)___(R)___Both___

*Audiogram:_____

Eyes_____

Ears_____

Nose_____

Throat_____

Teeth_____

Skin_____

Lymphatics_____

Lungs_____

Heart_____

Abdomen_____

Genitalia/hernia_____

Peripheral pulses_____

Cervical spine/neck_____

Back_____

Shoulders_____

Arm/elbow/wrist/hand_____

Knees/hips_____

Ankles/feet_____

Lab:

*Urine_____

*Hemoglobin or HCT_____

and/or Fe Stores_____

*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
(name of child/ward)
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, 1996

Form H 0001 5-68

CUMULATIVE HEALTH RECORD

ANNUAL PHYSICAL INSPECTION

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

SEX _____

CHECK DISEASES HAD (✓)

SCARLET FEVER ( ) SMALL POX ( ) PERTUSSIS (WHOOPING COUGH) ( ) CHICKEN POX ( ) MUMPS ( ) MEASLES ( ) RHEUMATIC FEVER ( ) DIPHTHERIA ( )

CODE: NO DEFECT ○ DEFECT × DEFECT CORRECTED ⊗ DEFECT BEING TREATED ⓣ

YEAR	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19
HEIGHT															
WEIGHT (Circle if under or overweight)															
VISION RIGHT															
VISION LEFT															
HEARING RIGHT															
HEARING LEFT															
TEETH															
THROAT															
SCOLIOSIS (Put "S" in block if Scoliosis is suspected. Code as above.)															
POSTURE															
SPEECH															
PARENTS/GUARDIAN NOTIFIED ( )															
EXAM (BY PHYSICIAN) ( )*															
EXAM (BY DENTIST) ( )*															

IMMUNIZATION HISTORY *

Dose	DPT MO DAY YR	POLIO MO DAY YR	MEASLES MO DAY YR	RUBELLA MO DAY YR	MUMPS MO DAY YR	Td (ADULT) MO DAY YR
1st						
2nd						
3rd						
4th						
5th						

REMARKS

(*When no medical examination is given, leave space blank)

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MEDICAL AND DENTAL EXAMINATIONS

YEAR	RECOMMENDATIONS BY PHYSICIAN OR DENTIST	NAME OF PHYSICIAN OR DENTIST
19		Physician
		Dentist
19		Physician
		Dentist
19		Physician
		Dentist
19		Physician
		Dentist
19		Physician
		Dentist
19		Physician
		Dentist
19		Physician
		Dentist

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 _____

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

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

L.F.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:

(reported 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

COMMONWEALTH OF VIRGINIA

Summary of Screening of Vision and Hearing
School Division Report

School Division: _____ Year: _____

Person Preparing Data: _____

Check Level: ____ Elementary (Grade 3) Total student population _____

____ Secondary (Grade 7) Total student population _____

____ Secondary (Grade 10) Total student population _____

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

Filed locally for administrative purposes.

L.F.010

3/95

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.

GRADE LEVEL AND SEX	NUMBER SCREENED	NUMBER SCREENED WITH SUSPECTED FINDINGS AND REFERRED THIS SCREENING	NUMBER OF RESPONSE TO REFERRAL	NUMBER SEEN BY PHYSICIAN AND REPORT INDICATES NO SIGNIFICANT FINDINGS	RESULTS OF MEDICAL EXAMINATION OF REFERRED STUDENTS							PREVIOUSLY DIAGNOSED AS SCOLIOSIS AND UNDER TREATMENT AT THIS TIME. IDENTIFY TYPE OF TREATMENT ON BACK OF FORM.	NO RESPONSE TO REFERRAL
					NUMBER SCOLIOSIS CASES DIAGNOSED	NO TREATMENT PRESCRIBED	REVIEW AS REQUESTED BY PHYSICIAN	EXERCISE AND/OR PT	BRACING	SURGERY	OTHER CONDITIONS DIAGNOSED (LIST ON BACK)		
1	2	3	4	5	6	7	8	9	10	11	12	13	14
5M													
5F													
6M													
6F													
7M													
7F													
8M													
8F													
9M													
9F													
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 HEADING DEFINITIONS

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:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Column 13 - No student in this column should have been included in any other column on this report.

_____	_____
_____	_____
_____	_____

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

Disposition: To be maintained and filed locally.