

**COMMONWEALTH OF VIRGINIA  
SCHOOL ENTRANCE HEALTH FORM**

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

**Part I - HEALTH INFORMATION FORM**

State law (Ref. Code of Virginia § 22.1-270) requires that your child is completely immunized and receives a comprehensive physical examination before entering public kindergarten. The parent or guardian completes this page of the form. The Medical Provider completes the second and third pages of the form. This form must be completed within one year before your child's first day in kindergarten or elementary school.

Name of School: \_\_\_\_\_ Grade: \_\_\_\_\_

Student's Name: \_\_\_\_\_

Student's Date of Birth: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_  
Mo. Day Yr. Sex:  \_\_\_\_\_ State or Country of Birth: \_\_\_\_\_

Student's Social Security #: \_\_\_\_\_ or I.D. #: \_\_\_\_\_

Student's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Mother or Legal Guardian: \_\_\_\_\_

Home Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Area Code Area Code

Name of Father or Legal Guardian: \_\_\_\_\_

Home Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Area Code Area Code

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

- Name: \_\_\_\_\_ Complete Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
- Name: \_\_\_\_\_ Complete Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Assessment of Student's Health**

*To the best of your knowledge, has your child had any problem with the following? Please check yes or no.*

Condition	Yes	No	Comments if "Yes"
Allergies (food, insects, drugs, latex)			
Allergies (seasonal)			
Asthma or breathing problems			
Attention-Deficit/Hyperactivity Disorder			
Behavioral problems			
Developmental problems			
Bladder problem			
Bleeding problems			
Bowel problem			
Cerebral Palsy			
Cystic Fibrosis			
Dental problems			
Diabetes			
Head or spinal Injury			
Hearing problems or deafness			
Heart problems			
Hospitalizations (when, why)			
Lead poisoning			
Muscular problems			
Seizures			
Sickle Cell Disease (not trait)			
Speech problems			
Surgery			
Vision problems			
Other:			

List all prescription and over-the-counter medications your child takes regularly: \_\_\_\_\_

Describe any other important health-related information about your child (i.e., feeding tube, oxygen support, hearing aid, etc.): \_\_\_\_\_

Name of your child's pediatrician or primary care provider: \_\_\_\_\_

Names of medical specialists or special clinics caring for your child: \_\_\_\_\_

Has your child ever seen a dentist? Yes: , No: . If yes, date of last appointment: \_\_\_\_\_

Check here if you want to discuss confidential information with the 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.): \_\_\_\_\_

Signature of Interpreter: \_\_\_\_\_ Date (Mo., Day, Yr.): \_\_\_\_\_