كومنولث فيرجينيا
النموذج الصحي للالتحاق بالمدرسة
نموذج المعلومات الصحية/تقرير الفحص البدني الشامل/شهادة التطعيم

الجزء الأول – نموذج المعلومات الصحية

يقتضي قانون الولاية (الرمز المرجعي لولاية فيرجينيا § 22.1-270) تلقي طفلك لكل التطعيمات اللازمة وخضوعه لفحص طبي شامل قبل الالتحاق بالمدارس الحكومية لرياض الأطفال أو المرحلة الابتدائية. يجب على ولي الأمر أو الوصي أو [illegible] هذه الصفحة [illegible] ثالث من النموذج.

ولاية أو بلد الميلاد:_____اللغة الأساسية التي يتحدث بها: _____

عنوان الطالب_____المدينة_____الولاية_____الرمز البريدي_____

اسم ولي الأمر أو الوصي القانوني الأول:_____الهاتف:_____-_____-_____العمل أو الخلوي:_____-_____-_____

اسم ولي الأمر أو الوصي القانوني الثاني:_____الهاتف:_____-_____-_____العمل أو الخلوي:_____-_____-_____

جهة الاتصال في حالات الطوارئ:_____الهاتف:_____-_____-_____العمل أو الخلوي:_____-_____-_____

المستشفى المفضل: _____

التأمين الصحي للطفل: بلا FAMIS FAMIS Plus (Medicaid) خاص/تجاري/ بدعم من جهة العمل _____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization

Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no earlier than one year before your child's entry into school.

Name of School:_____ Current Grade:

Student's Name: _____
Last

					Comments
			conditions or deafness		
Attention-Deficit/Hyperactivity Disorder			**Heart conditions**		
Behavioral/Psych/Social conditions			**Lead poisoning**		
Developmental conditions			**Muscle conditions**		
Bladder conditions			**Seizures**		
Bleeding conditions			**Sickle Cell Disease (not trait)**		
Bowel conditions			**Speech conditions**		
Cerebral Palsy			**Spinal injury**		
Cystic fibrosis			**Surgery**		
Dental Health conditions			**Vision conditions**		

Describe any other important health-related information about your child (Feeding tube , Trach , Oxygen support, Hearing aids, Dental appliance, Wheelchair, Hospitalizations, etc.):

Box 2. Medications

List all prescription, emergency, over-the-counter, and herbal medications your child takes regularly (Home/ School):

Medication Name	Dosage	Time Administered (Home/School)	Notes
1.			
2.			
3.			
4.			

Additional

applicable)			

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Part II - Certification of Immunization

Check if the student's Immunization Records are attached using a separate form signed by HCP ☐

See Section II for conditional enrollment and exemptions.

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box. Please contact your local health department for assistance with foreign vaccine records.

Student Name:			**Date of Birth :** / /	**Sex:**
Race (Optional):	**Ethnicity:**	**Hispanic**	**Non-Hispanic**	

IMMUNIZATION	**RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN**		
Diphtheria, Tetanus, Pertussis Vaccine (DTP, DTaP)	**1**	**2**	**3**

MEDICAL EXEMPTION: As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

_____

_____

_____

DTP/DTaP/Tdap :[ ]; DT/Td:[ ]; OPV/IPV:[ ]; Hib:[ ]; PCV:[ ]; RV:[

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth.

Student's Name: _____ Date of Birth: ____/____/____ Sex: ☐ M ☐ F

Health Assessment

Date of Assessment: ____/____/____

Weight: _____ lbs. Height: _____ ft. _____ in.

Body Mass Index (BMI): _____ BP _____

- ❑ Age / gender appropriate history completed
- ❑ Anticipatory guidance provided

Physical Examination

1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment

	1	2	3		1	2	3		1	2	3	
HEENT				Neurological				Skin				
Lungs				Abdomen				Genital				
Heart				Extremities				Urinary				

Tuberculosis Screening

Check the box that applies:

☐ No risk for TB infection identified ☐ No symptoms compatible with ☐ Risk for TB infection or 92.57 (ed)]TJ ET Q 2.32 3.68 61.24 1
