STUDENT SCREENING PROCEDURES

1. All Children, within 60 administrative working days of initial enrollment in a Pittsylvania County School, SHALL be screened in the following areas to determine if formal assessment is indicated:

Areas	Person(s) Responsible
Speech, Voice and Language	Speech Therapists/School Staff
Vision	School Nurses
Hearing	School Nurses

2. All children (through grade three), within 60 administrative working days of initial enrollment in a Pittsylvania County School, SHALL be screened by a school staff member for fine and gross motor functions to determine if formal assessment is indicated.

3. All students currently enrolled in grades 3, 7, and 10 will be screened in vision and hearing.

School Nurse Screenings

	K	1	2	3	4	5	6	7	8	9	10	11	12	New Student	New Referral for Sp. Ed.
Vision	X			X				X			X			X	X
Hearing	X			X				X			X			X	X
Scoliosis Information						X	X	X	X	X	X				
Height (As Time Allows)	X			X				X			X				
Weight (As Time Allows)	X			X				X			X				

Vision screening and hearing screening will be completed by the school nurse and recorded on the individual pupil's cumulative health record as well as on the computer health program used by the school nurse.

Parents shall be notified of any physical defects detected during the screening. When parents request assistance, the teacher will refer the child to the school nurse using the approved referral form.

Heights and weights are not mandated by the State Department of Education, but are recommended at intervals throughout the school years to determine that the student is maintaining a proper growth curve. This will be done by the school nurse as time allows.

Health Services

Health services is comprised of three full time School Nurse Coordinators and a full time School Nurse position in every school.

- The School Nurse Coordinators are registered nurses whose responsibilities include, but are not limited to: overseeing the delivery of healthcare in each school by the school nurse, providing supervision, training and updates for the computer health system, coordinating and teaching classes in the following: CPR, First Aid, Administration of Insulin and Glucagon, and Medication Administration. The School Nurse Coordinator coordinates/implements the VHSL requirements as related to the wrestling program.

- The Full Time School Nurse position is filled by either a licensed practical nurse or a registered nurse. These nurses work full time for the purpose of giving medications to the students and providing care to the ill or injured, performing vision and hearing screenings as required, reviewing physical and immunization records of students, maintaining up to date student health records, documenting on the student health system and maintaining student confidentiality.

Tdap Booster Required for Rising Sixth Grade Students

The 2006 General Assembly passed a law which requires all 5th grade students to receive a tetanus, diphtheria, pertussis (Tdap) booster shot *prior to entering the sixth grade*.

This requirement does not apply to children who have documentation of having received a dose of tetanus containing vaccine (Tetanus [T], Tetanus Diphtheria [Td], Tetanus Diphtheria Acellular Pertussis [Tdap]) within the last five years. This shot may be listed as T, Td, DTap, and/or Tdap. Please review your child's shot record. .

Parents **MUST** provide official documentation of the booster dose or immunization within the last five years to your child's school. This documentation must be from a public health agency or private physician. Please provide the documentation to your child's school prior to the 6th grade middle school open house.

The Pittsylvania County Health Department (434-432-7232 or 1-866-434-7232) offers free immunizations. **These clinics are by appointment**. Additional free immunization clinics are offered at the Danville Health Department (434-799-5190). Parents may also choose to obtain this immunization at a private physician's office for a fee.

Your attention to this matter is critical so that your child does not miss the opening of the school year. If your child has already received the Tdap immunization, please provide documentation to his/her school as soon as possible. If you are not sure whether your child has had this immunization, please check with your doctor or call the school nurse at your child's school to see if your child needs the shot.

6/6/2011

MEDICAL DOCUMENTATION REQUIRED FOR SCHOOL ATTENDANCE (2010-2011 SCHOOL YEAR)

Elementary School (grades K – 5):

Physical Requirements – MUST have physical exam performed within one year prior to entering a public school (see reverse side)

Immunization Requirements – MUST have documentation of up-to-date immunizations as required by the Code of Virginia (see reverse side)
Strongly suggested - HPV vaccination for girls 9 years old and older

Conditional Enrollment applies ONLY to those students who have received one dose of a series, i.e. DTaP, IPV and Hepatitis B and have a plan from a physician or health care provider to complete the immunization requirements within 90 school days. (Conditional enrollment does not apply to MMR or Varicella vaccinations.)

Middle School (grades 6 – 8):

Physical Requirements – NONE

Immunization Requirements – MUST have documentation of up-to-date immunizations as required by the Code of Virginia (see reverse side)
Students in grades 6-8 MUST have received their Tdap or tetanus containing vaccine within 5 years prior to entering middle school.
Strongly Suggested - Meningococcal vaccination

Conditional Enrollment applies ONLY to those students who have received one dose of a series, i.e. DTaP, IPV and Hepatitis B and have a plan from a physician or health care provider to complete the immunization requirements within 90 school days. (Conditional enrollment does not apply to MMR or Varicella vaccinations.)

High School (grades 9 – 12)

Physical Requirements – NONE

Immunization Requirements – MUST have documentation of up-to-date immunizations as required by the Code of Virginia (see reverse side)
In addition, students entering 9th ,10th, or 11th grades for the 2011-2012 school year must have received a Tdap or tetanus containing vaccine as stated in the middle school requirements above.
Strongly suggested: Meningococcal vaccination if not given during middle school years

Conditional Enrollment applies ONLY to those students who have received one dose of a series, i.e. DTaP, IPV and/or Hepatitis B and have a plan from a physician or health care provider to complete the immunization requirements within 90 school days. (Conditional enrollment does not apply to MMR or Varicella vaccinations.)

STUDENT MUST HAVE REQUIRED DOCUMENTATION BEFORE HE/SHE WILL BE ALLOWED TO ATTEND PITTSYLVANIA COUNTY SCHOOLS

Revised May 31, 2011

PITTSYLVANIA COUNTY SCHOOLS

PHYSICAL EXAMINATION AND MINIMUM IMMUNIZATION REQUIREMENTS FOR SCHOOL ENTRY

Code of Virginia, Section 22.1 – 270. Preschool Physical Examinations.

A. **No pupil shall be admitted** for the first time to any public kindergarten or elementary school in a school division unless such pupil shall furnish, prior to admission, (i) a report from a qualified licensed physician, or a licensed nurse practitioner or licensed physician assistant acting under the supervision of a licensed physician, of a comprehensive physical examination of a scope prescribed by the State Health Commissioner performed within the 12 months prior to the date such pupil first enters such public kindergarten or elementary school or (ii) records establishing that such pupil furnished such report upon prior admission to another school or school division and providing the information contained in such report.

B. The physician, or licensed nurse practitioner or licensed physician assistant acting under the supervision of a licensed physician, making a report of a physical examination required by this section shall, at the end of such report, summarize the abnormal physical findings, if any, and shall specifically state what, if any, conditions are found that would identify the child as handicapped.

Code of Virginia, Section 22.1 – 271.2, Immunization Requirements. The *Code of Virginia* requires that **no student shall be admitted** by a school unless at the time of admission the student or his parent or guardian submits documentary proof of immunization to the admitting official of the school or unless the student is exempted from immunization pursuant to subsection C or is a homeless child or youth.
(NOTE: Subsection C, Exceptions relates to Medical Exemption and Religious Exemption. These requirements apply to students in grades K – 12)

- Pittsylvania County School Board Policy JHCA relates to the physical examinations of students.

- Pittsylvania County School Board Policy JHCB relates to student immunizations. (Currently under revision to reflect updated Virginia immunization requirements)

Revised May 11, 2010

PITTSYLVANIA COUNTY SCHOOLS
P.O. Box 232 • 39 Bank Street S.E. • Chatham, Virginia 24531

Mr. James E. McDaniel
Division Superintendent

MEDICATION PROCEDURE

Parents are expected to give medications at home on a schedule other than during school hours if at all possible. No medication may be taken by a student at school except as herein provided. This procedure will provide safety, consistency, and confidentiality when it is necessary that a medication be taken during school hours.

GENERAL GUIDELINES FOR ALL MEDICATIONS

1. Medications given/prescribed once, twice, or three times daily should be given at home.
2. Parent/guardian permission is required for any medication taken by a student.
3. **All medications are required to be presented to the school office by a parent/guardian. It is the parent's/guardian's responsibility to consult with the school nurse in person or by phone regarding any medication. Failure to follow the medication procedure protocol may result in disciplinary action in accordance with the Student Code of Conduct.**
4. All medications must be presented in the original container labeled with the student's name, date, and name of medication. If there is any discrepancy, whatsoever, between the label on the bottle, the parent's/guardian's instructions, or the doctor's order (if indicated), the student will not be allowed to take the medication.
5. When the parent/guardian has completed Section B of the Medication Permission Form (SHS-1), medication is in a properly labeled container, and a physician has completed Section A of the Medication Permission Form (SHS-1) (if indicated), the student may take the prescribed dose of medication. **Medicine must be taken in the presence of a designated adult** and documented on the medication log. **All medications are to be kept locked up with limited access by designated adults.**
6. In the absence of a school nurse, the principal or designee will be responsible for assigning personnel to assist students taking medication and for periodic monitoring of the Medication Procedure.
7. The Medication Permission Form (SHS-1) must be updated at the beginning of each school year or when there is a change of dosage.
8. Medication not picked up at the close of the school year (or sooner if indicated) will be destroyed. Reminder by letter or telephone call to the parent/guardian for medications(s) to be picked up will be made before the close of the school year (or sooner if indicated).
9. Exceptions to these procedures may be necessary depending on individual circumstances.
10. If you have any questions regarding this procedure, please call School Health Services, extension 5028, at one of the numbers listed below.

Revised 1/7/11

CHRONIC MEDICATIONS

These are prescription medications taken by a student throughout the school year. Examples in this category are medications prescribed for asthma, ADD/ADHD, seizures, ulcers, migraines, diabetes, and emergency situations.

- Sections A and B of the Medication Permission Form (SHS-1) must be completed.
- The medication must be in the original prescription container.
- Certain medications (i.e. inhalers and Epi-pens) may be kept with the student for emergency use. The school nurse will have additional documentation, which is mandatory, before a student will be allowed to carry his/her own emergency medication. The principal's signature giving authorization is required.

ACUTE MEDICATIONS

These are prescription medications taken by the student on a short-term basis during the school year (i.e. antibiotics).

- Section B of the Medication Permission Form (SHS-1) must be completed.
- Section A of the Medication Permission Form (SHS-1) must also be completed if the prescription is to be taken for longer than **two weeks**. Any medication not taken during this two week period will be discarded if not picked up by the parent/guardian.
- The medication to be taken at school should be labeled by the Pharmacist in a separate container from that to be taken at home. (This prevents transporting a medication back and forth daily.)

OVER-THE-COUNTER MEDICATIONS

These are medications purchased over-the-counter for short-term treatment of minor illnesses. Examples in this category are cough syrups, cough drops, cold remedies, and pain relievers. Any over-the-counter medication must be in the original container and labeled with the student's name. Non-prescription medication must be appropriate for the student's age and weight, according to package directions.

- Section B of the Medication Permission Form (SHS-1) must be completed.
- Section A of the Medication Permission Form (SHS-1) must be completed for medication which is taken for more than **three** consecutive school days, contains aspirin (acetylsalicylate, salicylic acid or salicylate) or is herbal/homeopathic.
- Requests for cough and cold remedies to be given will be effective for **one week**. After that time, medication not taken or picked up will be discarded.

SELF-ADMINISTRATION OF MEDICATION

Sharing, borrowing, distributing, manufacturing or selling any medication is prohibited. Permission to self-administer prescription or non-prescription medication may be revoked if the student violates this policy and the student may be subject to disciplinary action in accordance with the Standards of Student Conduct.

PITTSYLVANIA COUNTY SCHOOLS
P.O. Box 232 • 39 Bank Street S.E. • Chatham, Virginia 24531

Mr. James E. McDaniel
Division Superintendent

MEDICATION PERMISSION FORM

I. **ALL** medications taken at school require:
   1. Parent/Guardian signature on Medication Permission Form (Section B).
   2. Original container.
   3. Explicit directions on the dosage and time medication is to be taken.

II. **A doctor must complete Section A of the Medication Permission Form for medications prescribed:**
   1. On a daily basis.
   2. "As needed" for treatment of chronic illnesses.
   3. For treatment of emergencies.
   4. That contain aspirin (acetylsalicylate, salicylic acid or salicylate).
   5. That are herbal/homeopathic.

III. ALL MEDICATION MUST BE BROUGHT TO THE SCHOOL BY A PARENT/GUARDIAN.

SECTION A: **PHYSICIAN'S ORDERS**

Student's Name _____ School _____ Date _____

Medication _____ Dose _____ Time _____

For treatment of _____

Adverse reactions expected _____

_____ _____ _____
Physician's Signature | Print Physician's Name | Telephone

SECTION B: **PARENTAL/GUARDIAN CONSENT**

Student _____ School _____ Grade _____

Student's Date of Birth _____ Homeroom Teacher _____

Parent/Guardian _____ Home Phone _____

Work Phone _____

I hereby request and authorize you to allow my son/daughter to take:

Medication _____ Dose _____ Time _____

I release school personnel from liability should reactions result from this medication. I authorize a representative of the school to share information regarding this medication with the above doctor.

_____ _____
Parent/Guardian Signature | Date

TELEPHONE NUMBERS: (434) 432-2761 • (434) 793-1624 (Danville) • (434) 656-6248 (Gretna) • FAX (434) 432-9560

SCHOOL ENTRANCE CHECKLIST
4 YEAR-OLD PROGRAM

Age-appropriate immunizations are required for admission to the 4-year-old program.

Directions: Fill out a checklist on all kindergarten students. Check appropriate spaces. If deficient write "No" in red ink. When resolved mark through the red "No" and write "corrected" in black ink, including the date resolved. A list of deficiencies is to be kept in a designated folder.

Student_____**Date of Birth**_____

DtaP, DTP, DT or Td ***If deficient, date resolved***_____
_____Is there a minimum of 4 doses with at least 6 months between doses 3 & 4? **OR**
_____Are there 3 doses with one after the 4th birthday, with at least 6 months between doses 2 & 3?

Polio (IPV) ***If deficient, date resolved***_____
_____Is there a minimum of 3 doses before age 4, with at least 6 months between doses 2 & 3?

Measles, Mumps, Rubella (MMR) ***If deficient, date resolved***_____
_____Is there a minimum of 1 Measles, 1 Mumps and 1 Rubella (MMR)?
_____Was the dose administered at age **12 months /365 days** or older?
_____If there are 2 doses, are there at least **28 days /4 weeks** between dose 1 and dose 2?

Hepatitis B ***If deficient, date resolved***_____
_____Is there a minimum of 3 doses?
_____Is there at least 1 month **(28days/4 weeks)** between the 1st and 2nd doses?
_____Are there at least 2 months **(56 days/8 weeks)** between the 2nd and 3rd doses?
_____Are there at least 4 months **(112 days/16weeks)** between the 1st and 3rd doses?
_____Is the 3rd dose given after age **6 months**?

Varicella (Chickenpox) ***If deficient, date resolved***_____
_____Has the student had 1 dose of the vaccine?
_____Was the dose administered at age **12 months/365 days** or older?
_____If 2 doses have been given before age 4, are there at least **3 months (84days/12weeks)** between doses?
OR
_____Is there documentation by a physician that the student has had the disease (chickenpox)?

VACCINES ADMINISTERED EQUAL TO OR LESS THAN 4 DAYS BEFORE THE MINIMUM INTERVAL OR AGE ARE VALID.

PHYSICAL CHECKLIST

_____*Is Part I (Health Information Form, page 1) filled out? ***If not, date resolved***_____
_____*Is the Health Information Form signed by the person completing Part I (page 1)? ***If not, date resolved***_____
_____*Is either the "do" or "do not" blank checked in the box at the bottom of the Health Information Form (page 1)?
If not, date resolved_____
_____*Has the physician, nurse practitioner or physician's assistant filled out the "Summary of Findings" box (located above the signature box) and any recommendations (if applicable) on page 4? ***If not, date resolved***_____
_____Is there a physical examination **signed** by a licensed physician, nurse practitioner, or physician's assistant?
If not, date resolved_____
_____Is the physical examination **dated**? ***If not, date resolved***_____
_____Was the physical exam done within one year of pupil first entering public kindergarten?
If not, date resolved_____

*applies to ***Commonwealth of Virginia School Entrance Health Form*** only

IMMUNIZATION EXEMPTIONS

Medical Exemptions
_____Is there a statement signed by a licensed professional stating contraindication to one or more vaccines?

Religious Exemption
_____Has the parent signed and had notarized the Certificate of Religious Exemption form (CRE-1)?

NOTIFY THE SCHOOL NURSE OF ANY STUDENTS WITH THE ABOVE MENTIONED EXEMPTIONS.

Person reviewing record:_____**Date:**_____

KINDERGARTEN SCHOOL ENTRANCE CHECKLIST 2011-2012

MINIMUM IMMUNIZATION REQUIREMENTS FOR ENTRY INTO SCHOOL

Directions: Fill out a checklist on all kindergarten students. Check appropriate spaces. If deficient write "No" in red ink. When resolved mark through the red "No" and write "corrected" in black ink, including the date resolved. A list of deficiencies is to be kept in a designated folder.

Student_____ **Date of Birth**_____

DtaP, DTP, DT or Td ***If deficient, date resolved***_____
_____Is there a minimum of 4 doses with at least one dose after the 4th birthday?

Polio (IPV) ***If deficient, date resolved***_____
_____Is there a minimum of 4 doses with at least one dose after the 4th birthday? **OR**
_____Are there 3 doses with one after the 4th birthday with at least **6 months** between doses 2 & 3?

Measles, Mumps, Rubella (MMR) ***If deficient, date resolved***_____
_____Is there a minimum of 2 Measles, 2 Mumps and 1 Rubella (MMR)?
_____Was the 1st dose administered at age **12 months /365 days** or older?
_____Are there at least **28 days /4 weeks** between dose 1 and dose 2?

Hepatitis B ***If deficient, date resolved***_____
_____Is there a minimum of 3 doses?
_____Is there at least 1 month **(28days/4 weeks)** between the 1st and 2nd doses?
_____Are there at least 2 months **(56 days/8 weeks)** between the 2nd and 3rd doses?
_____Are there at least 4 months **(112 days/16weeks)** between the 1st and 3rd doses?
_____Is the 3rd dose given after age **6 months**?

Varicella (Chickenpox) ***If deficient, date resolved***_____
_____Has the student had 2 doses of the vaccine?
_____Was the 1st dose administered at age **12 months/365 days** or older?
_____Are there at least **4 weeks /28days** between dose 1 and dose 2?
OR
_____Is there documentation by a physician that the student has had the disease (chickenpox)?

VACCINES ADMINISTERED EQUAL TO OR LESS THAN 4 DAYS BEFORE THE MINIMUM INTERVAL OR AGE ARE VALID.

KINDERGARTEN PHYSICAL CHECKLIST

_____*Is Part I (Health Information Form, page 1) filled out? ***If not, date resolved***_____
_____*Is the Health Information Form signed by the person completing Part I (page 1)? ***If not, date resolved***_____
_____*Is either the **"do"** or **"do not"** blank checked in the box at the bottom of the Health Information Form (page 1)?
If not, date resolved_____
_____*Has the physician, nurse practitioner or physician's assistant filled out the "Summary of Findings" box (located above the signature box) and any recommendations (if applicable) on page 4? ***If not, date resolved***_____
_____Is there a physical examination **signed** by a licensed physician, nurse practitioner, or physician's assistant?
If not, date resolved_____
_____Is the physical examination **dated**? ***If not, date resolved***_____
_____Was the physical exam done within one year of pupil first entering public kindergarten?
If not, date resolved_____
***applies to *Commonwealth of Virginia School Entrance Health Form* only**

IMMUNIZATION EXEMPTIONS
Medical Exemptions
_____Is there a statement signed by a licensed professional stating contraindication to one or more vaccines?
Religious Exemption
_____Has the parent signed and had notarized the Certificate of Religious Exemption form (CRE-1)?
NOTIFY THE SCHOOL NURSE OF ANY STUDENTS WITH THE ABOVE MENTIONED EXEMPTIONS.

Person reviewing record:_____ **Date:**_____

IMMUNIZATION CHECKLIST Grades 1-12
2011-2012

MINIMUM IMMUNIZATION REQUIREMENTS FOR ENTRY INTO SCHOOL

Directions: Fill out this checklist for all students entering grades 1-12. Check appropriate spaces. If deficient write "No" in red ink. When resolved mark through the red "No" and write "corrected" in black ink, including the date resolved. A list of deficiencies is to be kept in a designated folder.

Student_____ **Date of Birth**_____

DtaP, DTP, DT or Td ***If deficient, date resolved***_____

1st Grade

_____Is there a minimum of 4 doses with at least one dose after the 4th birthday?

Grades 2-12

_____Is there a minimum of 3 doses with at least one after the 4th birthday? **OR**
6 doses before the 4th birthday?

Tdap, Td ***If deficient, date resolved***_____

_____Is there a dose within 5 years of entering 6th grade? (Applies to 6th, 7th, 8th, 9th, 10th and 11th grades only)

Polio (OPV/IPV) ***If deficient, date resolved***_____

1st Grade

_____Is there a minimum of 4 doses with at least one dose after the 4th birthday? **OR**
Are there 3 doses with one after the 4th birthday with at least **6 months** between doses 2 & 3?

Grades 2-12

_____Is there a minimum of 3 doses with at least one dose after the 4th birthday? **OR**
Are there 4 doses before the 4th birthday?

Measles, Mumps, Rubella (MMR) ***If deficient, date resolved***_____

1st Grade

_____Is there a minimum of 2 Measles, 2 Mumps and 1 Rubella (MMR)?

Grades 2-12

_____Is there a minimum of 2 Measles, 1 Mumps, and 1 Rubella (MMR)?

Grades 1-12

_____Was the 1st dose administered at age **12 months/365 days** or older?
_____Are there at least **28 days/4 weeks** between dose 1 and dose 2 of MMR?

Hepatitis B ***If deficient, date resolved***_____

_____Is there a minimum of 3 doses?
_____Is there at least 1 month **(28days/4weeks)** between the 1st and 2nd doses?
_____Are there at least 2 months **(56 days/ 8 weeks)** between the 2nd and 3rd doses?
_____Are there at least 4 months **(112 days /16 weeks)** between the 1st and 3rd doses?
_____Is the 3rd dose given after age **6 months**?

OR Recombivax

_____Are there 2 doses?
_____Was the 1st dose given between the ages of 11-15 years?
_____Was the 2nd dose given 4 to 6 months after the 1st dose?

Varicella (Chickenpox) ***If deficient, date resolved***_____

_____Has the student born on or after January 1, 1997 had 1 dose of the vaccine?
_____Has the student in 1st grade had 2 doses of the vaccine?
_____Was the 1st dose administered at age **12 months/365** days or older?
_____Are there at least **4 weeks/28days** between dose 1 and dose 2 (if 2 doses given)?

OR

_____Is there documentation by a physician that the student has had the disease (chickenpox)?

VACCINES ADMINISTERED EQUAL TO OR LESS THAN 4 DAYS BEFORE THE MINIMUM INTERVAL OR AGE ARE VALID.

Person reviewing record_____ **Date**_____

See reverse (if applicable) for School Physical Checklist, Grades 1-5

Rev 6/2/11

SCHOOL PHYSICAL CHECKLIST (Grades 1 – 5)

_____*Is Part I (Health Information Form, page 1) filled out? *If not, date resolved*_____
_____*Is the Health Information Form signed by the person completing Part I (page 1)? *If not, date resolved*_____
_____*Is either the **"do"** or **"do not"** blank checked in the box at the bottom of the Health Information Form (page 1)? *If not, date resolved*_____
_____*Has the physician, nurse practitioner or physician's assistant filled out the "Summary of Findings" box (located above the signature box) and any recommendations (if applicable) on page 4? *If not, date resolved*_____
_____Is there a physical examination **signed** by a licensed physician, nurse practitioner, or physician's assistant? *If not, date resolved*_____
_____Is the physical examination **dated**? *If not, date resolved*_____
_____Was the physical exam done within one year of pupil first entering public kindergarten or elementary school? *If not, date resolved*_____

*applies to ***Commonwealth of Virginia School Entrance Health Form*** only

IMMUNIZATION EXEMPTIONS

Medical Exemptions

_____Is there a statement signed by a licensed professional stating contraindication to one or more vaccines?

Religious Exemption

_____Has the parent signed and had notarized the Certificate of Religious Exemption form (CRE-1)?

NOTIFY THE SCHOOL NURSE OF ANY STUDENTS WITH THE ABOVE MENTIONED EXEMPTIONS.

Person reviewing record:_____**Date:**_____

Revised 6/2/11

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 longer than one year before your child's entry into school.

Name of School: _____ Current Grade: _____

Student's Name: _____
Last First Middle

Student's Date of Birth: ____/____/_____ Sex: _____ State or Country of Birth: _____ Main Language Spoken: _____

Student's Address. _____ City: _____ State: _____ Zip: _____

Name of Mother or Legal Guardian: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Name of Father or Legal Guardian: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Emergency Contact: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head injury, concussions		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Lead poisoning		
Developmental problems			Muscle problems		
Bladder problem			Seizures		
Bleeding problem			Sickle Cell Disease (not trait		
Bowel problem			Speech problems		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example, feeding tube, hospitalizations, oxygen support, hearing aid, etc.):

_____

_____

List all prescription, over-the-counter, and herbal medications your child takes regularly:

_____

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

Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

Child's Health Insurance: ____ None ____ FAMIS Plus (Medicaid) ____ FAMIS ____ Private/Commercial/Employer sponsored

I, _____ (do___) (do not___) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. ***This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.***

Signature of Parent or Legal Guardian: _____ Date: _____/_____/_____

Signature of person completing this form: _____ Date: _____/_____/_____

Signature of Interpreter: _____ Date: _____/_____/_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

Section I

To be completed by a physician or his designee, registered nurse, or health department official.
See Section II for conditional enrollment and exemptions.

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.
Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

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

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	1	2	3	4	5
*Tdap booster (6th grade entry)	1				
*Poliomyelitis (IPV, OPV)	1	2	3	4	
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age	1	2	3	4	
*Pneumococcal (PCV conjugate) *only for children <2 years of age	1	2	3	4	
Measles, Mumps, Rubella (MMR vaccine)	1	2			
*Measles (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
*Rubella	1		Serological Confirmation of Rubella Immunity:		
*Mumps	1	2			
*Hepatitis B Vaccine (HBV) ☐ Merck adult formulation used	1	2	3		
*Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine	1	2			
Meningococcal Vaccine	1				
Human Papillomavirus Vaccine	1	2	3		
Other	1	2	3	4	5
Other	1	2	3	4	5

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Minimum requirements are listed in Section III).

Signature of Medical Provider or Health Department Official: _____ **Date (*Mo., Day, Yr.*):** ___/___/___

Student's Name:_____ Date of Birth: |___|___|___|

Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date.

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

_____

_____

_____.

DTP/DTaP/Tdap:[___]; DT/Td:[___]; OPV/IPV:[___]; Hib:[___]; Pneum:[___]; Measles:[___]; Rubella:[___]; Mumps:[___]; HBV:[___]; Varicella:[___]

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

Signature of Medical Provider or Health Department Official:_____ **Date (*Mo., Day, Yr.*):**|___|___|___|

RELIGIOUS EXEMPTION: The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

CONDITIONAL ENROLLMENT: As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on _____.

Signature of Medical Provider or Health Department Official:_____ **Date (*Mo., Day, Yr.*):**|___|___|___|

Section III
Requirements

For Minimum Immunization Requirements for Entry into School and Day Care, consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations (Ref. *Code of Virginia* § 32.1-46(a)). **(requirements are subject to change.)**

Part III – COMPREHENSIVE PHYSICAL EXAMINATION REPORT

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

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

Health Assessment

Date of Assessment: ____/____/_____

Weight: _____lbs. Height: _____ ft. _____ in.

Body Mass Index (BMI): _____ BP_____

☐ Age / gender appropriate history completed

☐ Anticipatory guidance provided

TB Risk Assessment: ☐ No Risk ☐ Positive/Referred

Mantoux results: _____ mm

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	☐	☐	☐

EPSDT Screens Required for Head Start – include specific results and date:

Blood Lead: _____ Hct/Hgb _____

Developmental Screen

Assessed for:	*Assessment Method:*	*Within normal*	*Concern identified:*	*Referred for Evaluation*
Emotional/Social				
Problem Solving				
Language/Communication				
Fine Motor Skills				
Gross Motor Skills				

Hearing Screen

☐ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.

	1000	2000	4000
R			
L			

☐ Screened by OAE (Otoacoustic Emissions): ☐ Pass ☐ Refer

☐ Referred to Audiologist/ENT ☐ **Unable to test – needs rescreen**

☐ Permanent Hearing Loss Previously identified: ___Left ___Right

☐ Hearing aid or other assistive device

Vision Screen

☐ With Corrective Lenses (check if yes)

Stereopsis	☐ Pass	☐ Fail		☐ Not tested
Distance	Both	R	L	Test used:
	20/	20/	20/	

☐ Pass ☐ Referred to eye doctor ☐ **Unable to test – needs rescreen**

Dental Screen

☐ Problem Identified: Referred for treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

Recommendations to (Pre) School, Child Care, or Early Intervention Personnel

Summary of Findings (check one):

☐ **Well child; no conditions identified of concern to school program activities**

☐ **Conditions identified that are important to schooling or physical activity** (complete sections below and/or explain here): _____

_____

_____

_____

_____

___ **Allergy** ☐ food: _____ ☐ insect: _____ ☐ medicine: _____ ☐ other: _____

Type of allergic reaction: ☐ anaphylaxis ☐ local reaction Response required: ☐ none ☐ epi pen ☐ other: _____

___**Individualized Health Care Plan needed** (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)

___ **Restricted Activity** Specify: _____

___ **Developmental Evaluation** ☐ Has IEP ☐ Further evaluation needed for: _____

___ **Medication**. Child takes medicine for specific health condition(s). ☐ Medication must be given and/or available at school.

___ **Special Diet** Specify: _____

___ **Special Needs** Specify: _____

Other Comments: _____

Health Care Professional's Certification (Write legibly or stamp):

Name : _____ **Signature:** _____ **Date:** ___/___/_____

Practice/Clinic Name: _____ **Address:** _____

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

PITTSYLVANIA COUNTY SCHOOLS
P.O. Box 232 • 39 Bank Street S.E. • Chatham, Virginia 24531

Mr. James E. McDaniel
Division Superintendent

HEARING SCREENING

Student's Name _____

School _____ Grade _____ Teacher _____

****

TO BE COMPLETED BY CLASSROOM TEACHER:
Dear Parent/Guardian:

Your child has exhibited the following behaviors, which indicated a possible hearing problem:

_____ Seems inattentive to auditory tasks.
_____ Mouth breathing, draining ears, or earache complaints.
_____ Frequent requests to repeat what has just been said.
_____ Irrelevant answers to questions.
_____ Indistinct speech.
_____ Watching the lips of the speaker.
_____ Talking either too loudly or too softly.
_____ Makes mistakes in following directions and taking dictation.

Comments: _____

_____

With your permission, our school nurse can perform a hearing screening. Please complete the next section of this form and return it to me.

_____ _____
Date Teacher's Signature

****

TO BE COMPLETED BY PARENT/GUARDIAN:

_____ I give my permission for my child to be given a hearing screening by the school nurse.

OR

_____ I do not give my permission for my child to be given a hearing screening by the school nurse.

Comments: _____

_____

_____ _____
Date Parent's Signature

TO BE COMPLETED BY THE SCHOOL NURSE:

Your child's hearing was checked at school today and the following results obtained:

_____ Hearing is found to be normal.
_____ He/she needs to see a doctor because:
_____ He/she was unable to pass the hearing screening.
_____ The ear canal is impacted with wax.
_____ Other: _____
_____
_____

Comments: _____
_____

If you have questions or are in need of assistance, feel free to contact me at the telephone numbers below or leave a message for me at your child's school

_____ _____
Date School Nurse's Signature

****

TO BE COMPLETED BY PROFESSIONAL EXAMINER:
PHYSICIAN'S FINDINGS AND RECOMMENDATIONS:

_____
Student's Name

_____ No significant findings at this time.
_____ Treatment necessary and prescribed.
_____ Referred to consultant for further evaluation.

Comments: _____
_____
_____
_____
_____

_____ _____
Date Physician (Please Print)

_____
Physician's Signature

RETURN COMPLETED FORMS TO SCHOOL NURSE FOR DOCUMENTATION AND FILING

Telephone Numbers: (434) 432-2761 – (434) 793-1624 (Danville) – (434) 656-6248 (Gretna) – Fax (434) 432-2893

PITTSYLVANIA COUNTY SCHOOLS

P.O. Box 232 • 39 Bank Street S.E. • Chatham, Virginia 24531

Mr. James E. McDaniel
Division Superintendent

VISION SCREENING

Student's Name _____

School _____ Grade _____ Teacher _____

****

TO BE COMPLETED BY CLASSROOM TEACHER:

Dear Parent/Guardian:

Your child has exhibited the following behaviors, which indicate a possible vision problem:

_____ Squints, blinks or rubs eyes excessively.
_____ Complains of headaches, nausea or dizziness after close work.
_____ Holds body tense when reading or concentrating visually.
_____ Thrusts head or body forward to see.
_____ Covers or closes one eye to read.
_____ Tilts head to read.
_____ Loses place on page, skips words, or reads same words twice.
_____ Is inattentive to board work, charts, or maps.
_____ Stops reading after brief period.
_____ Reverses or confuses words, syllables or letters.
_____ Verbally expresses difficulty seeing.

Comments: _____

_____

With your permission, our school nurse can perform a vision screening. Please complete the next section of this form and return it to me.

_____ _____
Date Teacher's Signature

****

TO BE COMPLETED BY PARENT/GUARDIAN:

_____ I give my permission for my child to be given a vision screening by the school nurse

OR

_____ I do not give my permission for my child to be given a vision screening by the school nurse.

Comments: _____

_____

_____ _____
Date Parent's Signature

TELEPHONE NUMBERS: (434) 432-2761 • (434) 793-1624 (Danville) • (434) 656-6248 (Gretna) • FAX (434) 432-9560

TO BE COMPLETED BY THE SCHOOL NURSE:

Your child's vision was checked at school today and the following results obtained:
_____ Vision is found to be normal.
_____ Even though your child wears glasses, a deficit still exists. Check with your child's optometrist/ophthalmologist to see if this is the best correction achievable at this time.
_____ A prompt professional examination is needed because he/she had a problem with the following: _____ far vision

_____ near vision
_____ weakness in the muscles of the eye and potential for blurring and double vision
_____ color discrimination

Comments: _____
_____

If your child receives free or reduced lunch and does not have Medicaid benefits, you may qualify for financial assistance with the eye exam and the purchase of glasses (if prescribed). Please call me at one of the telephone numbers listed below if you need assistance or have any questions.

_____ _____
Date School Nurse Signature

****

TO BE COMPLETED BY VISION PROFESSIONAL:
PHYSICIAN'S FINDINGS AND RECOMMENDATIONS:

_____
Student's Name

_____ No significant findings at this time
_____ Correction necessary and prescribed
_____ Referred to consultant for further evaluation

Comments: _____
_____
_____

_____ _____
Date Physician (Please Print)

_____
Physician's Signature

RETURN COMPLETED FORM TO SCHOOL NURSE FOR DOCUMENTATION AND FILING

Telephone Number: (434) 432-2761 (Chatham) – (434) 793-1624 (Danville) – (434) 656-6248 (Gretna) – Fax: (434) 432-2893

PITTYSLVANIA COUNTY SCHOOLS
School Health Services
P. O. Box 232, 39 Bank Street, S. E.
Chatham, Virginia 24531
1-434-432-2761

Scoliosis: Information and Screening Steps

Scoliosis is a musculoskeletal disorder in which there is a sideways curvature of the spine. Two curves are usually identified, in opposite directions of each other, creating an "S" or "C" shape to the spine. Idiopathic scoliosis is the most common type and generally occurs after the age of 10. Girls are more likely than boys to have scoliosis.
The school district is sending this information home with all students in grades 5 through 10, so that you may screen for this disorder at home.

The cause of scoliosis is unknown in most cases and the largest percentages of cases do not require treatment. Treatment can vary from observation or bracing to surgery. Progressive scoliosis in the growing child can lead to not only an asymmetrical body, it can lead to back pain, headaches, shortness of breath, leg, hip and knee pain, menstrual-cycle disturbances and chronic fatigue. It is also associated with a higher incidence of osteoporosis later in life. In the event you find that your child has an abnormal curving of the spine or you suspect scoliosis, contact your physician or health care provider. They will most likely do x-rays to determine the degree of curvature. The severity of the curvature will indicate what treatment is needed. Early treatment is important so that normal growth and development aren't hindered and the above symptoms don't restrict activity and mobility.

Simple steps to screen your child for scoliosis:

- Have your child stand in front of you with their arms at their sides. Have them stand erect with good posture and looking forward. Stand about 10 feet back and observe them for symmetry. Is one shoulder higher than the other? Does one hip look higher than the other? Does the head tilt or lean to one side more than the other?

- Now have the child turn around so their back is to you. Have them bend forward like they are going to touch their toes. Have them stay in this position while you look across their back. Does one side of the back seem higher than the other side? Does one shoulder blade protrude more than the other? Does one hip seem higher than the other? Is the spine curved sideways?

If you answer yes to any of these questions, it is recommended that you contact your physician or health care provider for further evaluation.

LAW REGARDING PHYSICAL EXAMINATION AND IMMUNIZATIONS

State law requires that before any child is admitted to kindergarten for the first time (including those currently enrolled in a preschool or four-year-old program), he/she must have a comprehensive physical examination. Forms will be provided at the time of registration for the certification of the physical examination and immunizations. This examination must be dated and signed by a licensed physician, nurse practitioner or physician's assistant no earlier than twelve months prior to the date he/she is to enter kindergarten. The child must be successfully immunized against the following communicable diseases: Diphtheria, Tetanus, Pertussis (Whooping Cough), Poliomyelitis, Rubeola (Red Measles), Mumps, Rubella (German Measles), Hepatitis B (HBV), and Chicken Pox (or physician's statement that the student has had chicken pox). The physical examination must also include results of a hemoglobin or hematocrit (for iron deficiency anemia), a lead screening and results of urinalysis.

Children who have enrolled and been accepted into a four-year-old program must also comply with physical examination requirements prior to entering school. Immunizations must be age-appropriate.

Parents are urged to make an appointment for the physical examination and the immunizations as soon after preschool registration as possible. Preschool examinations through the Pittsylvania/Danville Health Department and area physicians are available by appointment. Appointments are difficult to get during late summer. Immediately after your child's physical examination, take or mail the completed form to the school where your child is registered. Children **will not** be allowed to enter school prior to the physical examination and adequate immunizations.

Each child enrolling in school for the first time must have a birth certificate and a social security number. The birth certificate and the social security card should be presented at the school on the day of registration. If the child does not have a birth certificate or a social security card, the school principal will advise the parents concerning procedures for securing these documents.

Parents are urged to contact the local school principal if they have any questions concerning school entrance ages for preschool registration.