MEDICAL FORMS INSTRUCTIONS

DUE DATE: FRIDAY, DECEMBER 12, 2025

Please go through the FOUR medical paperwork forms carefully. Read all instructions and information. Read the instructions and required information and kindly complete all necessary fields on each form. Before submitting, make a copy to keep for your records.

NOTE: A: In lieu of the School Entrance Health Form supplied in this PDF file, you can submit a copy of your current School Physical Examination Form.

B: Everyone must complete and submit the **Conditions for Healthcare Services** and **Consent to Accompany Minor Patient** Forms in this PDF file.

Email (preferred) a completed set of forms and documents (scanned as one PDF, if possible) to: **HousePageSupervisor@house.virginia.gov**

OR mail a completed set of forms and documents to: Virginia House of Delegates Clerk's Office Attn: G. Paul Nardo VA House of Delegates P.O. Box 406 Richmond, VA 23218

QUESTIONS? Please contact:
The House Clerks Office
804.698.1619
HousePageSupervisor@house.virginia.gov

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 kindergarten or elementary school. The paform. This form must be completed no ear	rent or g	uardian completes t	his page (Part I) of the form. The Medical Pro	l examination l ovider comple	before entering public tes Part II and Part III of the			
Name of School:					Current Gr	ade:			
Name of School:									
Student's Name:Last			First		Middle	-			
Student's Date of Birth://	_ Sex:	State or C	ountry of l	Birth:	Main Lan	guage Spoken:			
Student's Address			_City	State	z	ip Code			
					Work or Cell;				
Name of Parent or Legal Guardian 2:									
Emergency Contact:									
						KOI Cell.			
Hospital Preference:									
Child's Health Insurance: None□ FA	MIS Plus	(Medicaid) F	AMIS 🗆	Private/Commercial/ Employer Sp	onsored□				
		Box 1	. Pre-Exi	sting Conditions		**************************************			
Condition	Yes	Comm	ents	Condition	Yes	Comments			
Allergies (food, insects, drugs, latex)				Diabetes: Type 1					
Please list Life Threatening Allergies:	-	y = -		Diabetes: Type 2		= =			
				Insulin pump	+				
Allergies (seasonal)				Head injury, concussion	- - 				
Asthma or breathing conditions				Hearing conditions or deafne	ess				
Attention-Deficit/Hyperactivity Disorder				Heart conditions					
Behavioral/Psych/ Social conditions				Lead poisoning					
Developmental conditions				Muscle conditions	1 1				
Bladder conditions				Seizures		WI 1000 Television Tel			
Bleeding conditions	00.50			Sickle Cell Disease (not trai	t)	W. W. C.			
Bowel conditions				Speech conditions					
Cerebral Palsy				Spinal injury					
Cystic fibrosis				Surgery					
Dental Health conditions				Vision conditions					
Describe any other important health-related informati	on about ye	our child (□ Feeding tub			Dental appliance	, ∩ Wheelchair, Hospitalizations, etc.):			
Ties all acceptance				Medications	1. 4 (11	/ Salara No			
Medication Name	otton, em	Dosage		erbal medications your child takes re Time Administered (Home/School)	gulany (Home	Notes			
1.		Dosage		i ine Administered (Nome/School)		Hotes			
	-					*****			
<u>2.</u> 3.			Te c		-	122 23000			
4.			+			2 72-51 12			
Additional Medications (Name, Dose, Time Admin	istered, No	ites)	.19						
Check here if you want to discuss confiden	tial inform	nation with the school	l nurse or o	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)									
I				ı care provider and designated provi orm. This authorization will be in p	-	_			
withdraw it. You may withdraw your author documentation of the disclosure is maintain	ization at ed in you	any time by contacti r child's health or sc	ng your ch holastic re	ild's school. When information is record.	eleased from y				
Signature of Parent or Legal Guardia	n:				Date:_				
Signature of Interpreter:					Date	//			

MCH213G reviewed 10/2020

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	

Section I

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.

contact your local health department for ass	sistance with foreign	vaccine record					
Student Name:	- Am dance		Date of Birth:	1 1	Sex:		
Race (Optional):	Ethnicity:	Hispanic	Non-Hispanic				
IMMUNIZATION	RECORD COMPL	ETE DATES (m	month, day, year) OF V	ACCINE DOSES (GIVEN		
Diphtheria, Tetanus, Pertussis Vaccine (DTP, DTaP)	1	2	3	4	5		
Diphtheria, Tetanus (DT) or Tdap or Td Vaccine (given after 7 years of age)	1	2	3	4	5		
Tdap Vaccine booster	1						
Poliomyelitis Vaccine (IPV, OPV)	1	2	3	4	5		
Haemophilus influenzae Type b Vaccine (Hib conjugate) only for children <60 months of age	1	2	3	4			
Rotavirus Vaccine (RV) only for children < 8 months of age	I	2	3	İ			
Pneumococcal Vaccine (PCV conjugate) only for children <60 months of age	1	2	3	4	270 170 7000		
Varicella Vaccine	1	2	Date of Varicella Immunity:	Disease OR Serolog	gical Confirmation of Varicella		
Measles, Mumps, Rubella Vaccine (MMR vaccine)	1	2					
Measles Vaccine (Rubeola)	1	Immunity:					
Rubella Vaccine	1	2	Serological Confi	firmation of Rubella Ir	mmunity:		
Mumps Vaccine	1	2	Serological Confi	firmation of Mumps Ir	mmunity:		
Hepatitis B Vaccine (HBV) Merck adult formulation used	1	2	3	4			
Hepatitis A Vaccine	1	2					
Meningococcal ACWY Vaccine	1	2					
Meningococcal B Vaccine	1	2	3				
Human Papillomavirus Vaccine (HPV)	1	2	3				
Influenza (Yearly)	1	2	3	4	5		
Other	1	2	3	4	5		
Other	1	2	3	4	5		
I certify that this child is ADEQUATELY OR child care or preschool prescribed by the State	R AGE APPROPRIAT		ZED in accordance with				
Signature of Medical Provider or Health Department Official: Date (Mo., Day, Yr.): / /							

MCH213G reviewed 10/2020 2

Section II
Conditional Enrollment and Exemptions

Conditional Enrollment and Exemptions					
Complete the medical exemption or conditional enrollment section as appropriate to include signature and date. This section must be attached to Part I Health Information (to be filled out and signed by parent).					
Student's Name: Date of Birth: Parent or Legal Guardian Name: Phone Number: Phone Number: Date of Birth: Parent or Legal Guardian Name: Phone Number: Phone Phone Number: Phone Phone Number: Phone Phone Number: Phone Pho					
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:[]; Measles:[]; Mumps:[]; Rubella:[]; VAR:[]; Men ACWY:[]; Men B:[]; Hep A:[]; HBV:[] This contraindication is permanent: [_], or temporary [] and expected to preclude immunizations until: 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:					
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.)

MCH213G reviewed 10/2020 3

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.

Stu	dent'	t's Name:				_Date of	Birth	V:								□ M	<u>□ </u>				
	Da	ate of Assessment:/	1			1 = V	Wiehin	поппа	-1	?=	= Abnorma	Physic:						-tion c	treg		- 4
.,		eight:lbs. Height:_			in.	11/2011/08/19	Illin .	UO1111-				.al III	4			rreu .c.	Çva				-
ent		ody Mass Index (BMI):				HEEN	·IT	$\downarrow 1$	2	3	Neurolo	1- cical	1	2	2 3	Skin		1	2	3	
Sm	1	Age / gender appropriate histo					-	- 		\vdash	Abdom		\vdash	+	-	Genita		+	\square	+	
ses		Anticipatory guidance provide	-	Alpietea		Lungs Heart	_	-	-	\vdash	Extremi		\vdash	+	+-	Urina		+	\square	+	\rightarrow
ASS		Anticipatory guidance provide	.a			Гісан			4	Ļ	EAUCIII	lites	<u>_</u>		4_	V11			4	\Box	
Health Assessment	$\frac{1}{c}$	Check the box that applies:		54	Tuber	rculosis (Scre	eenir	12		(f) (g)	22.				lei		1			
He	1	No risk for TB infection	iden	tified		ymptoms e TB dise			le w	/ith	-	□ Ri	isk f	for T	ΓB in	fection	or sy	/mptoi	ms ic	denti	fied
J	Te	est for TB Infection: TST IC	GRA	Date:		Reading			m	- 7	TST/J	I IGRA F	Rest	ıılt:	n No	egative	.—	P	Positi	ive	
		XR required if positive test t														egative Abnori		•	Uu.	V-C	
1		PSDT Screens Required for											_	_		_			—	—	
		55			-																
	Die	ood Lead:	_			<u> </u>	Heur	Hgo _											20.00	-All periods	
		Assessed for:		Assessment M	1ethod:		Wit	ithin no	orma	ıl		Concern	n ide	entifi	ied:		Refe	ferred fo	or Ev	valu a t	tion
व	ļ	Emotional/Social							_		(_						_	_	
Developmental Screen	₌ †	Problem Solving												_					_	_	
elopme	<u> </u>	Language/Communication	_					—		+											
vek	á ļ	Fine Motor Skills		1			11111	1000					_	_	_		_		_	_	
Ď	-	Gross Motor Skills			2		-		-	-							+				
	\Box	☐ Screened at 20dB: Indicate	42 Pa	- (D) or Refer (F	(a) in each be		+										Ш_				
		☐ Screened at 20dB: Indicat						חמי	الم. الم	1	**-1 _{na} /	,/i.L.			Tīn.			- 1,-	-01		
Hearing	a	1000			4000	·					Audiologis					able to to					
ear	å	R 1000	+	2000	4000		r	□ Perr	maner	nt H	Icaring Lo	oss Previ	iousl	ly id	ientific	ed: 🗆	ı Lest		Right	ıŧ	
₩ ~							Г	□ Hea	ıring :	, aid c	or another	a assistiv	ve de	evice	e e						
		L								_											
e e		☐ With Corrective Lenses (Ch	neck i	if yes)		THE REAL PROPERTY.						blems Ide	lenti!	fied:	: Refe	rred for	Treatr	ment	_	_	
Vision Screen	7	Stereopsis Pass			Not tested		(ਵ	la.	□ No P	Problem:	ı: Ref	ferre	ed for	preventi	.ion				
St	1	Distance Both R		L Test used	;d:		i i	/	e	Screen	□ No F	Referral:	: Alr	ready	y rece	iving de	ental cr	are			
sion	1	20/ 20/	21	20/			1	/		1 002		able to p		-	-						
Vir	9	- P Deferred to ave	100					/	L		100			/L			_	_	-	-	
<u> </u>	_	□ Pass □ Referred to eye Summary of Findings			.o test-neeus	rescreen		-													
ا جُ ا	ď.	□ Well child; no conditi			oncern to s	school pr	mgrai	m act	ivitic	es											
ja ja	ALL	☐ Conditions identified									mplete s	ections	bel	ow	and/c	or expla	ain he	:re):			
SC (ۇ ك																				
Pre L	4	Allergy: food:									eine:					er:		*,		3. 2	
Recommendations to (Pre) School, Child Care or Early Intervention	ly . inel	Type of allergic rea															o-inje	ector	Вυ)thei	:: <u> </u>
Sins Fra	CSOT	Restricted Activit	ty Sp	pecify:				-			•	, 50,000	3 a	رطنا	y, u,)					
afic	Per P	Developmental E	Evalua	ation 🗆 Has I	IEP o Fu	rther eva	aluati	on ne	eder	d for	r:		_	_		- 1000				22832-	<u>.</u>
end	Ą	Medication. Child	d take	es medicine for	or specific he	health con	nditio	on(s).			□ Medic								at sc	choo'	آر.
真り	ڋ	Special Diet Speci																			,
CO.	á	Special Needs Spe																			_
28 0	<i>-</i>	Other Comments:								_	1.21			_						_	
Це	leh	Carrieral's Cort	102.20	II Alluita la	this or et		77.,	1 male)	Y cox			-120		at		- 4 all	f th		
		Care Professional's Certi- ation entered above is accurate									OX, I ceru	tity with	a an	Clec	trona.	2 Signaci	ure in	iat an c	of the	2	
	ormati me:) (en.	er name and on.	le on signa.	ure and a	laic	.lires			gnature:_								Daf	te:	
	_	ce/Clinic Name:	_			Add	iress	:: _											_		
		:				-															
	/11				A 44/A -							JA4									

MEDICATION ADMINISTRATION GUIDELINES

In striving to maintain a healthy and safe working environment for Pages, the Clerk's Office believes that shared responsibility is best achieved by open communication, mutually understood agreement, and a clear delineation of expectations of what amounts to "routine" administration of medication(s).

It is the responsibility of the House Page Program to ensure that Pages administering medication and/or using medical equipment is done with parental consent and in a safe, consistent manner.

It is the responsibility of the Pages – in coordination with their parents / guardians and healthcare providers – to develop a medication regimen plan, which includes securely storing medications / prescriptions at the Omni Hotel as well as having in-place a responsible practice / regimen of self-administration or usage when appropriate and as prescribed during the duration of the Page program.

Neither Page Program Staff nor Hotel Chaperones will administer, monitor or safeguard medications or treatments prescribed to a Page program participant by a licensed healthcare professional.

- Parents / guardians are expected to develop a medication administration regimen in coordination
 with a Page's Primary Care Physician when administering routine medication / treatment is a
 necessary daily requirement for self-management. If applicable, Pages must return the
 second page of these guidelines to be completed by a healthcare provider and signed by a
 parent / guardian, if/when appropriate. Completed forms will be kept strictly confidentially
 on-file with Page Coordinators and Hotel Chaperones.
- There is no registered nurse / healthcare provider readily or immediately available to your child to maintain or administer medications while serving as a Page.
- Parents / guardians will assume responsibility for their Page's medication safekeeping, storage and coordination at the hotel accommodations. It is recommended that parents / guardians supply an appropriate amount of medication for a week's (Sunday evening-Friday afternoon) self-maintenance rather than bringing a full prescription to Richmond.
- It is a Page's responsibility to self-administer daily medications <u>prior</u> to leaving the Omni Hotel as prescribed for daily use and in coordination with your primary care physician and parents' acknowledgment / authorization. <u>Medication should not leave the hotel</u>, unless for such condition as diabetes, asthma or allergy as specified in the medication administration form.
- Parents / guardians are required to keep both Page Coordinators and Hotel Chaperones apprised of any changes or additions to the <u>Medication Administration Approval Form</u> (next page) as changes or modifications are made during the program's duration.
- Pages are <u>not permitted</u> to share any prescribed or nonprescribed / over-the-counter medication with a fellow Page or any other on the Capitol Square or at the hotel accommodations ever, at any time. <u>Any known incidents of medication sharing will be dealt with severely, with immediate termination from the program. No known incidents of a Page potentially jeopardizing the health and safety of themselves and their peers will be excused.</u>

The House Clerk reserves the right to modify the above stated guidelines and/or implement additional guidelines as necessary.

MEDICATION ADMINISTRATION APPROVAL FORM 2026

To be completed by the Page's Health Care Provider and returned to Page Program Staff:

Completion of this form indicates approval by both a Health Care Provider and Parent / Guardian for a House Page to regularly and/or routinely administer his / her medication as described / prescribed below and has been instructed in its proper use and safe storage.

Page Name:
Medication/Treatment:
Dosage, Frequency, Route:
Diagnosis:
Special Instructions, Side Effects, Comments:
HealthCare Provider Signature:
Health Care Provider PRINTED Name:
Health Care Provider Address:
Health Care Provider Telephone:
Date:
Parent / Guardian Signature:
Date:

Name:

MR#

Special Service Indicator:

VCU Health System MCV Hospitals and Physicians Richmond, Virginia 23298

(Patient Identification)

CONDITIONS FOR HEALTHCARE SERVICES

<u>Authorization for Medical Treatment</u>: I authorize and consent to healthcare services including, but not limited to, diagnostic procedures and medical treatment at and by the Medical College of Virginia Hospitals and Clinics (hereinafter collectively referred to as "MCVH") and MCV Physicians (hereinafter "MCVP"). I acknowledge that no guarantees or promises have been made to me as to the result to be obtained from such services.

Teaching Hospital: I understand that MCVH is a teaching hospital and that as such, healthcare services may be provided by qualified individuals in training. I further understand that for teaching and research purposes, patient records may be reviewed by students, trainees, employees and faculty members of MCVH, MCVP and VCU. I also understand that clinical photographs may be taken and that biological materials may be retained following completion of necessary diagnostic and therapeutic procedures. Photographs and biological materials may be used for teaching, study and research purposes and may be published without individually identifying me.

<u>Deemed Consent (HIV/Hepatitis):</u> I understand that if a healthcare provider is exposed to my blood or other body fluids in a manner which may transmit disease, I may be tested for infection with Human Immunodeficiency Virus (HIV, the virus which causes Acquired Immune Deficiency Syndrome (AIDS)) or Hepatitis B or C viruses. I further understand that the results of any such test will be shared with me and the exposed healthcare provider, and that the Virginia Department of Health will be notified and appropriate counseling provided if the results are positive.

Medicare Lifetime Signature Agreement (if applicable): I authorize any holder of medical or other information about me, and their agents, to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carriers, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and I request payment under Medicare be made either to me or to the provider, physician or other supplier for services or supplies furnished by the provider, physician, or other supplier.

Financial Agreement: In consideration for healthcare services provided to me by MCVH and/or MCVP for this and all subsequent services, I agree to pay MCVH and MCVP in accordance with their regular rates and terms of payment. I assume full financial responsibility for payment of all charges associated with the healthcare services provided to me including any portion of hospital or physician charges not paid by insurance carriers, workers' compensation or any other third party. Such unpaid charges may include, but are not limited to, deductible and coinsurance amounts and private room charges. Should my account be referred for collection, I agree to pay all collection costs and expenses, including attorneys fees, and I waive homestead and all other exemptions to such debt. I further agree that any lawsuit to collect sums owed by me shall be brought in the City of Richmond.

Assignment of Benefits: In consideration for healthcare services provided to me by MCVH and/or MCVP for this and all subsequent services, I hereby assign to MCVH and MCVP any and all rights, benefits and claims I may have under any policy of insurance (hospitalization, major medical, automobile, liability, workers' compensation, and any other) and the proceeds from any claim that I may have for injuries. Such assignment hereby authorizes direct payment to MCVH and MCVP under and/or from any such policy of insurance or proceeds.

Personal Belongings and Valuables: I acknowledge that I have been instructed to send home personal belongings, valuables and currency, including credit cards. I also acknowledge that I have been informed that MCVH has a safe for small valuables such as jewelry and currency and that it is my responsibility to request use of the safe for such items. I understand that valuables not picked up within 90 days of discharge will be disposed of by MCVH without further liability or responsibility. I also understand that MCVH and MCVP are not responsible for any damage to or theft or loss of dentures, eyeglasses, contact lenses, hearing aids, or any other valuables or personal belongings that I keep in my possession.

Patient Self-Determination Act: I acknowledge that I have been asked whether I have an advance directive such as a living will or healthcare durable power of attorney. I also acknowledge that I have been provided with written information concerning (1) a patient's right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to make advance directives, and (2) MCVH's policy regarding implementation of those rights. Living Will? \(\text{Q}\) Yes \(\text{Q}\) No Healthcare Durable Power of Attorney? \(\text{Q}\) Yes \(\text{Q}\) No

Co-Guarantor: I ______, understand that by signing this document, I agree to accept financial responsibility for healthcare services provided by MCVH and/or MCVP to the patient identified below. If the patient is unable to sign at registration, I accept this "Conditions for Healthcare Services" on behalf of the patient.

I certify that I have reviewed this document in full, understand its terms, and have had the opportunity to ask questions regarding its contents. I understand that this document is valid and remains in effect unless revoked by MCVH or MCVP. I certify I received a notice of privacy practices.

VCU Health System Is a Smoke Free Environment

Patient:		Date	Co-Guarantor: Signature		Date
Print Name	SS#:		Print Name	Rel. to Pt.:	
Witness:		Date	SS#:		
Unable to Sign at Registration: ☐ Re	eason				1
Patient Received Above Information:	Yes 🗆 No	•	Signature	Printed Name	Date



Consent to Accompany Minor Patient

Į,	authorize/permit the designated individual(s)
listed below to bring my child,	, to MCV Physicians (MCVP) for
medical attention, if necessary, in those instant	ces when I am unable to do so.
·	res deemed necessary by a physician or other licensed inde- to medical treatments and non-invasive procedures, and the ad- sly, or by injection.
Designated Individuals (Please Print):	· ·
Name	Relationship to child Chaperone
Name	Relationship to child
Name	Relationship to child
Name	Relationship to child
val at the MCVP clinic. I further understand th	will be required to present proper picture identification upon arri- at when designated individuals without proper picture identifica- document to accompany my child, MCVP will not provide gen- d).
This Consent Form will be maintained in the p be furnished by telephone.	atient's medical records. Updates to this list of Individuals may
35.	*
Name of Parent or Legal Guardian (Please Prin	Date
Last four digits of SS#, mother's maiden name necessary	and/or other identifying information for verbal consent when
, i	e.
Signature of Parent or Legal Guardian	Emergency Phone Number