MEDICAL FORMS INSTRUCTIONS

DUE DATE: FRIDAY, DECEMBER 27, 2019

Please go through the medical paperwork carefully. Read all instructions and information. If you need to meet with your healthcare provider, please schedule an appointment as soon as possible.

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.

Before submitting, make a copy to keep for your records.

You may submit the Medical and Additional Forms together via:

MAIL completed set of forms to:
Virginia House of Delegates
Attn: Jay Pearson
PO Box 406
Richmond, VA 23218

or EMAIL completed set of forms (PDF format) to:
Jay Pearson at jpearson@house.virginia.gov

or FAX completed set of forms with a cover sheet to:
Jay Pearson
804.771.7903 (Dedicated fax line. Only Jay will receive information)

QUESTIONS? PLEASE CONTACT:
Jay Pearson, 804.698.1524 or jpearson@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) 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 Name: ____________________________ First Name: ____________________________ Middle Name: ____________________________

Student's Date of Birth: __/__/____ Sex: ____________________________ State or Country of Birth: ____________________________

Main Language Spoken: ____________________________

Student's Address: ____________________________ City: ____________________________ State: ____________________________ Zip: ____________________________

Name of Parent or Legal Guardian 1: ____________________________________________________________

Phone: ____________________________ Work or Cell: ____________________________

Name of Parent or Legal Guardian 2: ____________________________________________________________

Phone: ____________________________ Work or Cell: ____________________________

Emergency Contact: ____________________________________________________________

Phone: ____________________________ Work or Cell: ____________________________

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

Describe any other important health-related information about your child (for example, feeding tubes, hospitalizations, oxygen support, hearing aid, dental appliances, 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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
<th>Date of Last Appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Pediatrician/primary care provider
Specialist
Dentist
Case Worker (if applicable)

Child's Health Insurance: ________ 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: __/__/____

MCH 213G reviewed 03/2014
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.

<table>
<thead>
<tr>
<th>IMMU NIZATION</th>
<th>RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Diphtheria, Tetanus, Pertussis (DTP, DTap)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>*Tdap booster (6th grade entry)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>*Poliovirus (IPV, OPV)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>*Haemophilus influenzae Type b (Hib conjugate)</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>*only for children &lt;6 months of age</td>
<td></td>
</tr>
<tr>
<td>*Pneumococcal (PCV conjugate)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>*only for children &lt;60 months of age</td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps, Rubella (MMR vaccine)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>*Measles (Rubella)</td>
<td>1 2</td>
</tr>
<tr>
<td>*Rubella</td>
<td>1 2</td>
</tr>
<tr>
<td>*Mumps</td>
<td>1 2</td>
</tr>
<tr>
<td>*Hepatitis B Vaccine (HBV)</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>□ Merck adult formulation used</td>
<td></td>
</tr>
<tr>
<td>*Varicella Vaccine</td>
<td>1 2</td>
</tr>
<tr>
<td>*Date of Varicella Disease OR Serological Confirmation of Varicella</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>*Hepatitis A Vaccine</td>
<td>1 2</td>
</tr>
<tr>
<td>*Meningococcal Vaccine</td>
<td>1 2</td>
</tr>
<tr>
<td>Human Papillomavirus Vaccine</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Other</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Other</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

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 (Reference Section III).

Signature of Medical Provider or Health Department Official: ___________________________ Date (Mo, Day, Yr.): __ / __ / __

MCH 213G reviewed 03/2014
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 (i), 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/Td[ ]; DTwP[ ]; OPV/IPV[ ]; Hib[ ]; Pneum[ ]; MMR[ ]; Varicella[ ]; Rubella[ ]; Mumps[ ]; HBV[ ]; Polio[ ]

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 CR-B-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.)

Certification of Immunization 03/2014

MCH 213G reviewed 03/2014
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.vabeunheath.org/schoolhealth.

Student's Name: ___________________________ Date of Birth: ______/_____/______

Physical Examination

- Date of Assessment: ______/_____/______
- Weight: _______ lbs, Height: _______ ft. _______ in.
- Body Mass Index (BMI): _______ BP: _______
- Age/gender appropriate history completed
- Anticipatory guidance provided

Health Assessment

- TBS: No risk for TB infection identified
- Risk for TB infection or symptoms identified
- PPD: TST (IGRA) Date: _______ TST Reading: _______ mm
- TST/IGRA Result: Positive
- CXR: Required if positive test for TB infection or TB symptoms.
- Symptoms: _______ Normal

Eyesight Screenings

- Assessed for: Vision
- Assessment Method: Vision
- Within normal: _______
- Concern identified: _______
- Referred for Evaluation: _______

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

- Screened by OAB (Otoscopy External Emissary): _______ Pass: _______
- Referral: _______

Hearing Screenings

- Screened: _______
- Wearing Corrective Lens: _______
- Screened: _______, _______, _______ Referral: _______
- Test used: _______

Vision Screenings

- Screened: _______, _______, _______, _______
- Test: _______
- Pass: _______
- Refer: _______
- Refer to eye doctor: _______
- Unable to test: _______

Dental Screenings

- Screened: _______
- Problem identified: _______
- No problem: _______
- No referral: _______

Summary of Findings

- Well child; no conditions identified of concern in school program activities
- Conditions identified that are important in schooling or physical activity (complete sections below and/or explain here):

- Allergy:
- Food:
- Insect:
- Medication:
- Other:
- Individualized Health Care Plan needed (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)
- Restricted Activity Specification
- Developmental Evaluation
- Has IEP
- Further evaluation needed
- Education: Child takes medicine for specific health condition(s):
- Special Diet: _______
- Special Needs: _______
- Other Comments: _______

Health Care Professional’s Certification

- Name: ___________________________ Signature: ___________________________
- Practice/Office Name: ___________________________ Date: ______/_____/______
- Phone: _______ Fax: _______ Email: ___________________________
I authorize and consent to healthcare services provided by MCV Hospitals and Clinics (collectively, “MCVH”) and/or by MCV Physicians (“MCVP”), including, but not limited to, diagnostic procedures and medical and surgical treatment. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained from receiving any such healthcare services.

1. Teaching Hospital: I understand that MCVH is a teaching facility and that qualified individuals, as part of their training at MCVH, may observe or participate in the delivery of healthcare services to me. For teaching purposes, I further understand that my patient records may be reviewed by students, trainees, employees, and faculty members of MCVH, MCVP, Virginia Commonwealth University and other similar hospitals, providers and students and Trainees.

2. Clinical Photographs and Biological Materials: In connection with healthcare services provided to me, I understand that clinical photographs may be taken and biological materials retained following completion of necessary medical procedures. For teaching, study, and research purposes, I agree that such clinical photographs may be published and biological materials used provided I am not individually identified. I will not receive compensation for such uses.

3. HIV/Hepatitis B or C Testing: 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.

4. Other Reportable Diseases: I understand that Virginia law requires positive laboratory values of certain diseases to be timely reported to the Virginia Department of Health. A list of all reportable diseases is available to me, upon my request.

GENERAL CONDITIONS OF ADMISSION

1. Personal Valuables: All personal valuables should be left at home or sent home with others upon admission. I understand and agree that neither MCVH nor MCVP are responsible for the loss, theft, or damage of any valuables or belongings I keep in my possession unless they are deposited in the hospital safe. I understand that items not picked up from the safe within 30 days of discharge will be disposed of by MCVH without further liability or responsibility. ____________ Patient/Representative’s Initials

2. Electrical Appliances: Small electrical appliances are permitted (electric razors, toothbrushes, etc.) but, only after they have been inspected and approved for use by the hospital staff.

3. Durable Medical Equipment / Home Care Services: I understand that my physician may order/recommend medical equipment, supplies, or home care services after I leave the hospital. I further understand that I have the right to select any vendor/provider to provide the equipment, supplies or care ordered by my physician.

4. Request for Release of Information: I understand that upon admission, I have been given a personal identification number (a “PIN”) and that sharing this PIN with anyone (my family members or others) will grant them access, upon request, to the information outlined in our Notice of Privacy Practices while I am a patient at VCUHS.

HM-R-0387 (rev. 10/2015)
Medical Records Committee

Medical Records Copy

Page 1 of 3
ADVANCED DIRECTIVE

We encourage all patients to complete an advance health care directive, which allows you to state your preference for medical treatment and to select a person to make your health care decisions in case you are unable to do so. I acknowledge that I have been asked whether I have an advance directive such as a living will or healthcare durable power of attorney. Please initial next to one of the applicable statements:

| I have completed an Advance Directive and have been requested to supply a copy to the hospital. | I have not completed an Advance Directive. I wish to complete one and I have received information on how to create and execute an Advance Directive. | I have not completed an advance directive and I do not wish to receive information on how to complete an advance directive at this time. |

RELEASE OF INFORMATION/PRIVACY NOTICE/PATIENT BILL OF RIGHTS

1. Release of Information: I authorize MCVH, MCVP and their respective employees and agents to release to my insurance companies, Medicare, Medicaid, or any other third party payer, if applicable, any healthcare or other information needed to determine benefits for related services.

2. Notice of Privacy Practices: I acknowledge I have received a Notice of Privacy Practices which describes the ways in which MCVH and/or MCVP may use and disclose my healthcare information for treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Compliance Services office designated on that notice if I have a question or complaint regarding privacy issues. 

3. Patient Bill of Rights and Responsibilities: I acknowledge I have received a Patient's Bill of Rights and Responsibilities.

Authorization for e-Prescribing/Provider Access to Prescription Monitoring Program

1. Electronic Prescriptions (e-Prescribing): I authorize MCVH and/or MCVP to use e-Prescribing for my prescriptions. Use of e-Prescribing means that MCVH and/or MCVP healthcare providers may electronically transmit prescriptions to the pharmacy of my choice and review my pharmacy benefit information and pharmacy prescription history. This authorization shall continue as long as I am an MCVH and/or MCVP patient, or until I withdraw the authorization in writing.

2. Access to Virginia Prescription Monitoring Program: I understand that prescribing healthcare providers at MCVH and/or MCVP may access the information contained in the Virginia Prescription Monitoring Program files on Schedule II, III and IV prescriptions dispensed to me.

ACKNOWLEDGMENT OF UNDERSTANDING

I, the undersigned, as the patient, or the parent, guardian, spouse or agent of the patient, hereby certify 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 will remain in effect unless revoked by MCVH or MCVP.

VCU HEALTH SYSTEM is a Smoke Free Environment

| Signed: ___________________ | Relationship to patient: ___________________ | Date: _______ Time: _______ |

HM-R-0387 (rev. 10/2015)
Medical Records Committee

Page 2 of 3
1. **Financial Responsibility**: I accept full financial responsibility for healthcare services provided to me by MCV Hospitals (MCVH) and MCV Physicians (MCVP). I understand that such responsibility includes co-insurance, deductibles, and payment for services that are not covered by a health insurance plan, government agency, workers’ compensation, or any other third party.

2. **Delinquent Accounts**: Should my account become delinquent, I agree to pay all costs of collection, including but not limited to, interest charges, collection agency fees, legal costs, and attorney fees of thirty-three and one-third percent (33 1/3%) of the unpaid balance turned over for collection. For purposes of collection of my account, I consent to receiving auto-dialed and/or artificial or prerecorded message calls to my cellular telephone and to any telephone number provided by me to MCVH and/or MCVP, including but not limited to, calls from MCVH, MCVP, and any account management company, contractor or debt collector retained by either MCVH or MCVP, I agree that any lawsuit to collect sums owed by me may be brought in the courts in and for the City of Richmond, and I consent to the jurisdiction thereof.

3. **Assignment of Benefits**: In consideration for healthcare services provided to me by MCVH, MCVP and/or others for this and all subsequent services, I hereby assign to MCVH, MCVP and others 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, including payment of authorized Medicare benefits on my behalf. A copy of this authorization may be used instead of the original.

4. **Direct Payment**: I hereby authorize payment directly to MCVH, MCVP and others for this and all subsequent services rendered by them that are reimbursable under any medical insurance plan or by any party responsible for payment of these fees.

5. **Automobile Accident Patients**: If you have been in an automobile accident, you may be entitled to payment from your automobile insurance if you have medical expense benefits coverage. By signing this assignment of benefits form you are giving to your health care provider the right to receive some or all of that payment directly from your automobile insurance company: If you have health insurance and your health care provider is in-network: as long as you provide information necessary to verify your health insurance coverage the health care provider may only bill the amount you owe for any copayment, coinsurance, or deductible to your automobile insurance company and you may be entitled to any remainder of your automobile insurance coverage. If you do not provide information necessary to verify your health insurance coverage, do not have health insurance, or your health care provider is not in your health insurance's provider network: your health care provider may bill their full charges to your automobile insurance. You may want to consult your insurance agent or attorney before signing or initialing this form. You are not required to sign/initial this form to receive care. Please be aware that Indigent discounts do not apply if you receive payment directly from your automobile insurance plan.

<table>
<thead>
<tr>
<th>Patient Name (or person authorized to sign for patient)</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

**Guarantor (other than patient)**: I understand that by signing below, I agree to accept personal financial responsibility for healthcare services provided by MCVH and/or MCVP to the patient identified above.

<table>
<thead>
<tr>
<th>Guarantor Name (Please Print)</th>
<th>Guarantor Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Guarantor Social Security Number</th>
<th>Guarantor Relationship to Patient</th>
</tr>
</thead>
</table>

**Patient Received Above Information**: ☐ Yes ☐ No

**Special Service Indicator**: ____________________________

**VCUHS Witness Name**: ____________________________ **VCUHS Witness Job Title**: ____________________________

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**VCUHS Health System**
**Richmond, Virginia 23298**

**CONDITIONS FOR HEALTHCARE SERVICES**

**FINANCIAL RESPONSIBILITY AND COLLECTION PRACTICES**
Consent to Accompany Minor Patient

I, ____________________________, authorize/permit the designated individual(s) listed below to bring my child, ____________________________, to MCV Physicians (MCVP) for medical attention, if necessary, in those instances when I am unable to do so.

I further authorize the performance of procedures deemed necessary by a physician or other licensed independent practitioner, including but not limited to medical treatments and non-invasive procedures, and the administration of medications orally, intravenously, or by injection.

Designated Individuals (Please Print):

Name ____________________________ Relationship to child ____________________________
Name ____________________________ Relationship to child ____________________________
Name ____________________________ Relationship to child ____________________________
Name ____________________________ Relationship to child ____________________________

I understand that all above named individuals will be required to present proper picture identification upon arrival at the MCVP clinic. I further understand that when designated individuals without proper picture identification, and/or individuals not designated in this document to accompany my child, MCVP will not provide general medical treatment (emergent care excluded).

This Consent Form will be maintained in the patient's medical records. Updates to this list of individuals may be furnished by telephone.

Name of Parent or Legal Guardian (Please Print) ____________________________ Date __________

Last four digits of SS#, mother's maiden name, and/or other identifying information for verbal consent when necessary

Signature of Parent or Legal Guardian ____________________________ Emergency Phone Number ____________________________