MEDICAL FORMS INSTRUCTIONS

DUE DATE: FRIDAY, DECEMBER 12, 2024

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

Name of School: ______________________________ Current Grade: __________

Student's Name: ______________________________
Last First Middle

Student's Date of Birth: ____/____/______ Sex: ______ State or Country of Birth:__________________Main Language Spoken: __________

Student's Address______________________ City__________ State__________ Zip Code__________

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: _____-_____-_____

Hospital Preference: ______________________

Child's Health Insurance: None☐ FAMIS Plus (Medicaid) ☐ FAMIS ☐ Private/Commercial/ Employer Sponsored☐ ______________

Box 1. Pre-Existing Conditions

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes: Type 1		
Please list Life Threatening Allergies:			Diabetes: Type 2		
			Insulin pump		
Allergies (seasonal)			Head injury, concussion		
Asthma or breathing conditions			Hearing conditions or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart conditions		
Behavioral/Psych/ Social conditions			Lead poisoning		
Developmental conditions			Muscle conditions		
Bladder conditions			Seizures		
Bleeding conditions			Sickle Cell Disease (not trait)		
Bowel conditions			Speech conditions		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental Health conditions			Vision conditions		

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

Box 2. Medications

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

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

Additional Medications (Name, Dose, Time Administered, Notes)

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)			

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 Interpreter: ______________________________Date_____/_____/______

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.

Student Name: **Date of Birth :** / / **Sex:**

Race (Optional): **Ethnicity:** **Hispanic** **Non-Hispanic**

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
Diphtheria, Tetanus, Pertussis Vaccine (DTP, DTaP)	1	2	3	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	1	2	3		
Pneumococcal Vaccine (PCV conjugate) only for children <60 months of age	1	2	3	4	
Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Measles, Mumps, Rubella Vaccine (MMR vaccine)	1	2			
Measles Vaccine (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
Rubella Vaccine	1	2	Serological Confirmation of Rubella Immunity:		
Mumps Vaccine	1	2	Serological Confirmation of Mumps Immunity:		
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

Certification of Immunization

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.*):** ___/___/____

Section II
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: ______________________________
Parent or Legal Guardian Name: ______________________________
Phone Number: ______________________________

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.*): |____|____|____|.

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

Physical Examination

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

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

Tuberculosis Screening

Check the box that applies:

☐ No risk for TB infection identified	☐ No symptoms compatible with active TB disease	☐ Risk for TB infection or symptoms identified

Test for TB Infection: TST IGRA Date:________ TST Reading____ mm TST/IGRA Result: ☐ Negative ☐ Positive

CXR required if positive test for TB infection or TB symptoms. CXR Date:__________ ☐ Normal ☐ Abnormal

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.

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

	1000	2000	4000
R			
L			

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

☐ Permanent Hearing Loss Previously identified: ☐ Left ☐ Right

☐ Hearing aid or another 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

☐ Problems Identified: Referred for Treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

☐ **Unable to perform**

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* ☐ *epinephrine auto-injector* ☐ 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) ☐ **By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).**

Name:______________________ **Signature:**______________________ **Date:**______

Practice/Clinic Name: ______________________ **Address:**______________________

Phone:______-______-__________ **Fax:** ______-______-__________ **Email:**______________________

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 *prior* to leaving the Omni Hotel as prescribed for daily use and in coordination with your primary care physician and parents' acknowledgment / authorization. Medication should not leave the hotel, 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 **Medication Administration Approval Form** *(next page)* as changes or modifications are made during the program's duration.

- Pages are **not permitted** 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. 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.

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

<u>MEDICATION ADMINISTRATION APPROVAL FORM</u>

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 #

(Patient Identification)

VCU Health System
MCV Hospitals and Physicians
Richmond, Virginia 23298

CONDITIONS FOR HEALTHCARE SERVICES

Authorization for Medical Treatment: 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.

Deemed Consent (HIV/Hepatitis): 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 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? ❑ Yes ❑ No Healthcare Durable Power of Attorney? ❑ Yes ❑ 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: ______________________________ Date __________
Signature Signature

______________________________ SS#: ______________________ ______________________________ Rel. to Pt.: ______________
Print Name Print Name

Witness: ______________________________ Date ______ SS#: ______________________________

Unable to Sign at Registration: ❑ Reason______________________________

Patient Received Above Information: ❑ Yes ❑ No VCU Representative: ______________________ ______________________ Date ________
Signature Printed Name

Special Service Indicator:

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___Chaperone___________

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