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. PreExisting 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:

Type	**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

A copy of child's immunization records is attached ☐

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 official of health department indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording the dates on this page, as long as the completed immunization record is attached to the School Entrance Health Form: Part II Certification of Immunization (MCH213G).

As per 12VAC5-110-70, the Certification of Immunization form must be signed and dated by the Medical Provider (physician or designee, registered nurse, or official of the health department) in the appropriate box below. Contact 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: _____/_____/_____

Section II
Conditional Enrollment and Exemptions

A qualified licensed physician, nurse practitioner, or physician assistant must 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 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 (or 180 days for Hepatitis B). **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 https://www.vdh.virginia.gov/immunization/requirements

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 and sign 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.vdh.virginia.gov/school-age-health-and-forms/school-health-forms-and-action-plans

Student 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 Sceeen

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

Hearing Sceeen

☐ 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 Sceeen

☐ With Corrective Lenses (Check if Yes)

Stereopsis: ☐ Pass ☐ Fail ☐ Not Tested

Distance	Both	R	L
	20/	20/	20/

Test Used:

☐ Pass ☐ Referred to Eye Doctor ☐ Unable to Test - Needs Rescreen

Dental Sceeen

☐ 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: _____ Address: _____

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

THE Siena SCHOOL®

Virginia Authorization Form for Schools to Administer Medications, Release and Indemnification Agreement

Part I – To Be Completed by the Parent/Guardian

I hereby authorize The Siena School (Siena) personnel to administer medication as directed by this authorization. I agree to release, indemnify, and hold harmless Siena and any of their officers, staff members, or agents from lawsuits, claims, expenses, demands, or actions, etc., against them for helping this student use medication, provided Siena staff members comply with the licensed prescriber, parent or guardian orders set forth in accordance with the provision of Part II below. I have read the procedures outlined on the back of this form and assume responsibility as required.

Student: _____ **Birth date:** _____

Prescription: ____Renewal _____ New If new, the first full day's dosage was given at home on: _____

Allergies _____

List all medication(s) the student is taking, including over-the-counter medication(s): _____

_____

_____ _____ _____

Parent/Guardian Signature **Phone Number** **Date**

Part II – To Be Completed by the Physician for Prescriptions or Parent for Over The Counter (OTC) Medications

PARENT OR GUARDIAN TO COMPLETE AND SIGN FOR OVER-THE-COUNTER MEDICATION PER MANUFACTURER'S RECOMMENDATION FOR RELIEF OF SYMPTOMS FOR HEADACHE, MUSCLE ACHE, ORTHODONTIC PAIN, OR MENSTRUAL CRAMPS AND FOR ANTIBIOTIC AND ANTIVIRAL MEDICATION FOR UP TO TEN CONSECUTIVE SCHOOL DAYS. LICENSED PRESCRIBER MUST COMPLETE AND SIGN FOR ALL OTHER MEDICATIONS.

****I have read the above parent/guardian information and assume the responsibilities as required.**

*****MUST USE A SEPARATE FORM FOR EACH PRESCRIPTION OR OTC MEDICATION*****

Name of Medication: _____ **Diagnosis (write out):** _____

Dosage: _____ **Frequency (write out):** _____ **Time(s) to be given at school:** _____

Route of Administration: _____ **Effective Dates: From:** _____ **To:** _____

Side Effects: _____

If PRN, must specify indication (signs/symptoms): _____

_____ _____

****Physician's Name (Print/Type)** ****Physician Signature** **Phone Number** **Date**

MD Address or stamp: _____ **Fax :** _____

SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of Emergency med. such as inhalers and EpiPens® must be authorized by the prescriber according to VA state medication policy.

****MD Prescriber's authorization** _____

Signature **Date**

Part III – To Be Completed By the School

_____**Parts I and II above are completed, including signatures.**

_____**Medication label and physician order are consistent.**

_____**Medication is properly labeled by pharmacist.**

_____**OTC Medication is in manufacturer labeled container.**

School Signature and Date _____

Information and Procedures

1. Medications should be taken at home whenever possible so that the student will not lose valuable classroom time or have a shortened lunch period. Any medication taken in school must have a parent or guardian-signed authorization; some medications also require licensed prescriber's orders. Medication must be kept in the school-approved location during the school day. **The parent or guardian must transport medications to and from school, except a high school student may carry an over-the-counter medication to and from the school office.**

2. No medication will be accepted by school personnel without receipt of completed and appropriate medication forms. Only a 30-day supply of medication should be brought in to school at a time.

3. A licensed prescriber may use office stationery or a prescription pad in lieu of completing Part II. Include the following information written in lay language with no abbreviations:

- Name of student
- Date of birth
- Reason for medication or diagnosis
- Name of medication
- Exact dosage to be taken in school (e.g., mg, ml, or cc)
- Time to take medication and frequency or exact time interval dosage is to be administered
  Sequence in which the medications should be taken in cases where more than one medication is prescribed
- If medication is given on an as-needed basis, specify the exact conditions or symptoms when medication is to be taken and the time at which it may be given again. ("Repeat as necessary" is unacceptable.)
- Duration or effective dates of medication order
- Licensed prescriber's signature and date
- Route of administration

4. All prescription medications, including licensed prescriber's prescription drug samples, must be in their original containers and labeled by a licensed prescriber or pharmacist. An over-the-counter medication must be in the original container with the name of the medication visible. The parent or guardian must label the original container with the following:

- Name of student
- Route of administration
- Exact dosage to be taken in school (e.g., mg, ml, or cc)
- Frequency or time interval dosage is to be administered

5. The first dose of any new medication must be given at home.

6. The parent or guardian is responsible for submitting a new form to the school at the start of the school year and each time there is a change in the dosage or in the time at which medication is to be taken.

7. Medication kept in the school will be stored in a locked area accessible only to authorized personnel.

8. Within one week after expiration of this authorization or on the last day of school, the parent or guardian must pick up any unused portion of the medication. Medications not claimed within that period will be destroyed.

9. The student is to come to the school predetermined location, at the prescribed time to receive medication. Parent or guardian should develop a plan with the student to ensure that the student goes to the school office at the appropriate time. Medication can be given no more than one half hour before or after the prescribed time.

10. Siena does not assume responsibility for authorized medication taken independently by the student.

11. In no case may any school member administer any medication outside the framework of the procedures outlined here and/or in Siena regulations.

12. The parent or guardian must provide Siena a supply of medication to be administered during the school day and/or field/overnight trips.

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: [ ] **Yes (higher risk for a severe reaction)** [ ] **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following foods: _____

THEREFORE:

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS



LUNG
Short of breath, wheezing, repetitive cough



HEART
Pale, blue, faint, weak pulse, dizzy



THROAT
Tight, hoarse, trouble breathing/ swallowing



MOUTH
Significant swelling of the tongue and/or lips



SKIN
Many hives over body, widespread redness



GUT
Repetitive vomiting, severe diarrhea



OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE
Itchy/runny nose, sneezing



MOUTH
Itchy mouth



SKIN
A few hives, mild itch



GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

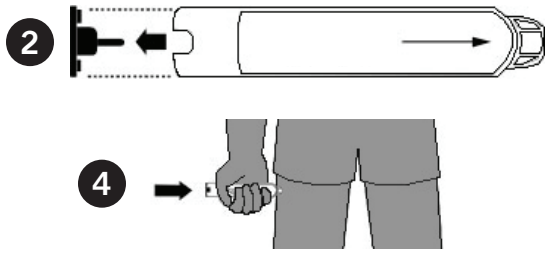
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

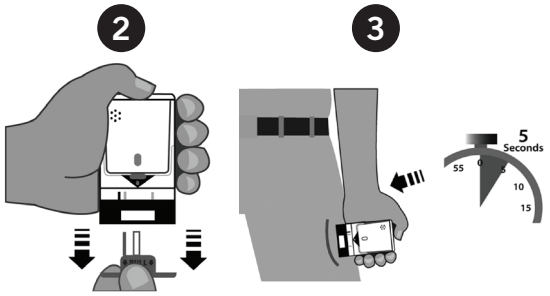
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled “1” and “2”.
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.)**:**

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

Clear Form

Virginia Asthma Action Plan

School: ***Effective Dates:***

Name		Date of Birth
Health Care Provider	Emergency Contact	Emergency Contact
Provider Phone #	Phone: area code + number	Phone: area code + number
Fax #	Contact by text? ☐ YES ☐ NO	Contact by text? ☐ YES ☐ NO

Medical provider complete from here down

Asthma Triggers (Things that make your asthma

☐ Colds ☐ Smoke (tobacco, incense) ☐ Pollen ☐ Dust ☐ Acid reflux ☐ Exercise ☐ Animals: _____ ☐ Pests (rodents, cockroaches) ☐ Other: ☐ Strong odors ☐ Mold/moisture ☐ Stress/Emotions

Season ☐ Fall ☐ Spring ☐ Winter ☐ Summer

Asthma Severity: ☐ Intermittent Persistent: ☐ Mild ☐ Moderate ☐ Severe

Green Zone: Go! — Take these CONTROL Medicines every day at home

You have **ALL** of these:
- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

Peak flow: _____ to _____
(More than 80% of Personal Best)
Personal best peak flow:

Always rinse your mouth after using your inhaler. Remember to use a spacer with your MDI when possible. ☐ No control medicines

☐ Advair _____, ☐ Alvesco_____, ☐ Arnuity ____, ☐ Asmanex ____

☐ Breo _____, ☐ Budesonide ____, ☐ Dulera _____, ☐ Flovent ____, ☐ Pulmicort ____

☐ QVAR Redihaler ____, ☐ Symbicort _____, ☐ Other: _____

MDI: ____ puff (s) ____ times per day or **Nebulizer Treatment:** ____ times per day

Singulair/Montelukast take _____mg by mouth once daily

For Asthma with exercise/sports add: MDI w/spacer 2 puffs, 15 minutes prior to exercise:
☐ Albuterol ☐ Xopenex ☐ Ipratopium *If asymptomatic not < than every 6 hours*

Yellow Zone: Caution! — Continue CONTROL Medicines and ADD RESCUE Medicines

You have **ANY** of these:
- Cough or mild wheeze
- First sign of cold
- Tight chest
- Problems sleeping, working, or playing

Peak flow: _____ to _____
(60% - 80% of Personal Best)

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)

MDI: _____ puffs with spacer every _____ hours as needed

☐ Albuterol 2.5 mg/3m1 ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent) 2.5mg/3m1

Nebulizer Treatment: one treatment every _____ Hours as needed

Call your Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week or if your rescue medicine does not work.

Red Zone: DANGER! — Continue CONTROL & RESCUE Medicines and GET HELP!

You have **ANY** of these:
- Can't talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show

Peak flow: < _____
(Less than 60% of Personal Best)

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)

MDI: _____ puffs with spacer **every 15 minutes,** for **THREE treatments**

☐ Albuterol 2.5 mg/3m1 ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)

Nebulizer Treatment: one nebulizer treatment **every 15 minutes,** for **THREE** treatments

Call 911 or go directly to the Emergency Department NOW!

I give permission for school personnel to follow this plan, administer medication and care for my child, and contact my provider if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/ monitoring devices. I approve this Asthma Management Plan for my child. With HCP authorization & parent consent inhaler will be located in ☐ clinic or ☐ with student (self-carry)

PARENT/Guardian _____ Date_____

SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER

CHECK ALL THAT APPLY

☐ **Student may carry and self-administer inhaler at school.**

☐ **Student needs supervision/assistance & should not carry the inhaler in school.**

MD/NP/PA SIGNATURE: _____ DATE _____

CC: ☐ **Principal** ☐ **Parent/guardian** ☐ **School Nurse or clinic** ☐ **Bus Driver** ☐ **Coach/PE** ☐ **Office Staff** ☐ **School Staff** ☐ **Cafeteria Mgr** **Transportation**

Virginia Asthma Action Plan approved by the Virginia Asthma Coalition (VAC) 03/2019

Blank copies of this form may be reproduced or downloaded from www.virginiaasthmacoalition.org

Based on NAEPP Guidelines 2007 and modified with permission from the D.C. Asthma Action Plan via District of Columbia, Department of Health, D.C. Control Asthma Now, **and District of Columbia Asthma Partnership**

EPILEPSY FOUNDATION®
Not another moment lost to seizures

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ❒ Yes ❒ No

If YES, describe process for returning student to classroom:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

❒ Contact school nurse at _____

❒ Call 911 for transport to _____

❒ Notify parent or emergency contact

❒ Administer emergency medications as indicated below

❒ Notify doctor

❒ Other _____

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

DPC772

VIRGINIA ADOLESCENT VACCINATION SCHEDULE

7 YEARS- 18 YEARS

Updated 2/2026

7-10 Years	11-12 Years	13 Years	16-18 Years
Catch-up Vaccines*	**HPV** 1st dose	**HPV** 6-12 months after 1st dose	
	MenACWY 1st dose		**MenACWY** 2nd dose (16 years and older).
	Tdap		**MenB****

Annual Flu Vaccine For Everyone 6 Months and Older

School Requirements

The Code of Virginia requires children entering daycare, public and private schools to give proof of vaccination before enrolling in school. The vaccines should be given based on the schedule recommended by the American Academy of Pediatrics and American Academy of Family Physicians. **Please visit our website to learn more about school immunization requirements and exemptions:** https://www.vdh.virginia.gov/immunization/requirements/

Vaccine Catch-Up & Dose Spacing*

If your child is missing any vaccines, be sure to ask your provider about the **catch-up** schedule so your child is fully protected. Doses of **MMR** and **Varicella** should be spaced **28 days** apart, should complete by Kindergarten.

HPV Vaccine

The **HPV** vaccine is the only vaccine that helps to prevent cancer! In **Virginia**, it is required **before** going to **7th** grade. For more information on **HPV** vaccine requirements and the **HPV** vaccine opt-out clause, please visit the following website: https://www.vdh.virginia.gov/content/uploads/sites/11/2025-Rising-7th-Graders-Letter_Signed_English.pdf. Please be sure your child finishes the **HPV** series vaccine by **age 13**, for the most protection. If your child is **15 years** or older at the time of the first shot of HPV, they will need **3 doses** for full protection.

Serogroup B Meningococcal Vaccine (MenB)**

Older teens and young adults **(ages 16-23)** can receive the **MenB** vaccine. Talk with your child's **health care provider** to learn if the **MenB** vaccine is right for your teen.

Health care providers - physicians, specialists, physician assistants, nurse practitioners, registered nurses, etc.



Vaccine Abbreviations

HepB	Hepatitis B vaccine
DTaP	Diphtheria, tetanus, and pertussis vaccine
Hib	Haemophilus influenza type b vaccine
HepA	Hepatitis A vaccine
MMR	Measles, mumps, and rubella vaccine
PCV	Pneumococcal Conjugate Vaccine
Tdap	Tetanus, diphtheria, and pertussis vaccine
MenACWY	Meningococcal Conjugate Vaccine (ACYW)
MenB	Meningococcal Conjugate Vaccine (B)

See current American Academy of Pediatrics recommended schedule for children and adolescents for additional information https://downloads.aap.org/AAP/PDF/AAP-Immunization-Schedule.pdf

VDH VIRGINIA DEPARTMENT OF HEALTH