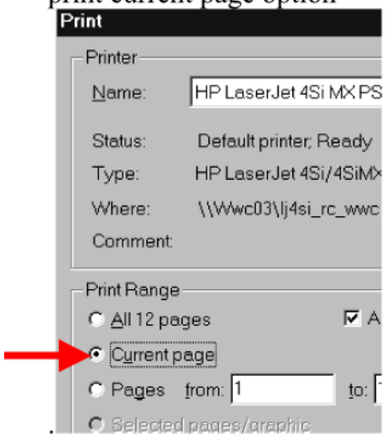
For students enrolling or re-enrolling in Fairfax County Public Schools

This form bundle allows you to enter data once and to have it appear in multiple locations. If you have more than one student, you can use the RESET button to clear out ALL student related information while keeping all of the parent data. The RESET button operates on ALL pages at once!

If you are using the free Acrobat Reader you can save the empty form for use later but not the data you enter in the fields. If you have the full Acrobat software version (5 or later) you can save the file with all of your data for use later.

To make sure you are printing only the pages you need, we recommend you review each page to make sure it is complete and accurate and then print that page by choosing the print current page option



FAIRFAX COUNTY PUBLIC SCHOOLS

Student Registration Form
Part A

FCPS Student ID

To Be Completed by Parent or Guardian

Student Legal Name (as it appears on the birth certificate) — Last / First / Middle

Student Previous Name (if any) — Last / First / Middle

Student Nickname	Date of Birth (mm/dd/yyyy)	Student Home Telephone (ten digits) ☐ unlisted		Gender ☐ Male ☐ Female	Grade Level

Ethnic Group and Race Categories The federal government **requires** that **both** these questions be answered and provides only the following categories for ethnic group and race. If both questions are not answered, school personnel are **required** to make selections for both.

1. Is this student Hispanic or Latino? *(choose only one)*
   - ☐ No, not Hispanic or Latino
   - ☐ Yes, Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)
2. What is the student's race? (*select all that apply*)
   - ☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment.)
   - ☐ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
   - ☐ **Black or African American** (A person having origins in any of the Black racial groups of Africa.)
   - ☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
   - ☐ **White** (A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.)

Other Children in Family

Name	Date of Birth

Residence Address of Student and Enrolling Parent — Street / Apt No. / City / State / Zip Code/Suffix

Dwelling Location (select only one)

☐ 5 City of Fairfax ☐ 9 Fairfax County ☐ 4 Fort Belvoir ☐ 6 Other (not Fairfax County)
☐ 1 Town of Clifton ☐ 2 Town of Herndon ☐ 3 Town of Vienna

Enrolling Parent — Relationship ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Self

Last / First / Middle

E-mail _____ Contact Numbers ten digits ☐ Unlisted Home _____ Work _____ Cell _____

Other Parent Resides With ☐ Yes ☐ No — Relationship ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Stepmother ☐ Stepfather ☐ Spouse

Last / First / Middle / Address (if different from above)

Contact Numbers ten digits ☐ Unlisted Home _____ Work _____ Cell _____

Other Parent Resides With ☐ Yes ☐ No — Relationship ☐ Mother ☐ Father ☐ Legal Guardian ☐ Stepmother ☐ Stepfather

Last / First / Middle / Address (if different from above)

Contact Numbers ten digits ☐ Unlisted Home _____ Work _____ Cell _____

Information from the Fairfax County Public Schools student scholastic record is released on the condition that the recipient agrees not to permit any other party to have access to such information without the written consent of the parent or guardian or of the eligible student.

FAIRFAX COUNTY PUBLIC SCHOOLS

Student Registration Form
Part B

Last First Middle

FCPS Student ID

Student Legal Name _____

Number of Years Previously in K-12	Number of Full Academic Years Completed in U.S.	Ever Received a Service from FCPS Before?	Ever Attended FCPS Before?	Name of Last School Attended in FCPS	Last Year Attended
	☐0 ☐1 ☐2 ☐3 ☐4 or more	☐ Yes ☐ No Previous ID _____	☐ Yes ☐ No		

Last School Attended NOT in FCPS

School Name

Street City State Zip Code

School Phone (ten digits)

School Fax (ten digits)

Country of Birth	Original U.S. Entry Date		Home Language (Complete SS/SE-82 Home Language Survey)	Parent Correspondence Language
Military Compact ☐ Yes ☐ No		☐2 Refugee ☐3 Non-Immigrant ☐4 Asylee ☐F1 Student Visa Holder ☐J1 Foreign Exchange Student		

☐ I affirm that the above registered student **has not been** expelled from school attendance at any private or public school in Virginia or another state for an offense in violation of School Board policies relating to weapons, alcohol, or drugs, or for the willful infliction of injury to another person.

☐ I affirm that the above registered student **has been** expelled from school attendance at a private or public school in Virginia or another state for an offense in violation of School Board policies relating to weapons, alcohol, or drugs, or for the willful infliction of injury to another person.

I am aware that making a false statement herein constitutes a class 3 misdemeanor. I am aware that Fairfax County Public Schools (FCPS) staff may verify residency documentation, including contacting landlords, to confirm Fairfax County residency. I am aware that if I move from Fairfax County that the above registered student may no longer be eligible to attend FCPS. I certify that all the information on this student registration form is true and correct to the best of my knowledge and belief.

Parent or Guardian Signature _____ Date _____ Print Name _____

To Be Completed by FCPS Staff (with input from parent or guardian)

Proof of Date of Birth	Date of Entry (current)	Original FCPS Entry Date	Original 9th Grade Entry Date	Student Assignment	
Birth Certificate Number _____ Affidavit with Supporting Documentation Code _____	_____ E _____ R _____			Placement Code	Base School

Transportation	Proof of Address Received	Homeless	Tuition Code	Contact Restriction
☐ Authorized to Ride Bus ☐ Not Authorized to Ride Bus	Document Type(s) _____	☐ Yes ☐ No		☐ Yes ☐ No

Special Education Program Code	AAP Status	ELP Level	ESOL Status	LEP Semesters in Virginia	Counselor	Homeroom	Teacher
☐1 R ☐2 S							

Current Enrolling FCPS School _____

FCPS Staff Signature _____ Date _____ Print Name _____

Information from the Fairfax County Public Schools student scholastic record is released on the condition that the recipient agrees not to permit any other party to have access to such information without the written consent of the parent or guardian or of the eligible student.

FAIRFAX COUNTY PUBLIC SCHOOLS

HEALTH INFORMATION

TO BE COMPLETED BY PARENT OR GUARDIAN EACH SCHOOL YEAR

PART 1 Parent Or Guardian To Complete. Parent or guardian is encouraged to participate in the development of an Individual Health Care Plan if needed.

Student Name Last	First	Middle	Sex ☐ M ☐ F	DOB

School Year	Grade	Teacher Name

Home Phone	Father Work Phone	Mother Work Phone

My child has a medical condition that may affect his or her school day ☐ NO ☐ YES (please complete Part 2)

Parent or Guardian Name (Print or Type)

Parent or Guardian Signature _____ Date

PART 2 Complete All Boxes That Apply To Your Child. Parent or guardian is responsible for providing the school with any medication, special food, or equipment that the student will require during the school day. Check with the school health room to obtain correct medication and procedural forms. If an individual school health care plan is indicated, parent or guardian is responsible for providing the school public health nurse with necessary medical information, appropriate authorization forms, and written consent to exchange information with the child's physician.

☐ ALLERGIES

Allergy Type

☐ Food List food(s) _____

☐ Medication List medicine(s) _____

☐ Bee sting _____

☐ Other (list) _____

Reactions Type ☐ Mild ☐ Severe Date of last severe reaction _____

☐ Coughing ☐ Hives ☐ Rash

☐ Difficulty breathing ☐ Local swelling ☐ Wheezing

☐ Generalized swelling ☐ Nausea ☐ Other _____

Currently prescribed medications and treatments

☐ Oral antihistamine (Benadryl, etc.) ☐ Epinephrine ☐ Other _____

☐ FOOD INTOLERANCE

☐ Due to Gastrointestinal (Digestive) distress List Foods _____

☐ Due to Religious preferences List Foods _____

☐ ASTHMA

Triggers ☐ Exercise ☐ Environmental ☐ Other (list) _____

Symptoms

☐ Chest tightness, discomfort, or pain ☐ Difficulty breathing ☐ Throat itch, tightness, or soreness

☐ Coughing ☐ Hoarseness ☐ Wheezing

☐ Other _____

Currently prescribed medications and treatments

☐ Inhalers ☐ Oral antihistamines ☐ Oral steroids

☐ Nebulizer ☐ Oral bronchodilator ☐ Peak flow monitoring

Date of last hospitalization related to asthma _____

CONTINUE ON REVERSE

☐ Diabetes

Currently prescribed medications and treatments

☐ Insulin ☐ Syringe ☐ Pen ☐ Pump

☐ Blood sugar testing ☐ Carbohydrate Counting

☐ Glucagon

☐ Oral medication(s) List medication(s) _____

Date of last hospitalization related to Diabetes _____

Is special scheduling of lunch or Physical Education required? ☐ NO ☐ YES

☐ Seizure Disorder

Type of seizure

☐ Absence (staring, unresponsive) ☐ Complex partial ☐ Generalized tonic-clonic (grand mal, convulsive)

☐ Other (explain) _____

Physical education restrictions ☐ NO ☐ YES

Medications needed *IN SCHOOL* ☐ NO ☐ YES List medication(s) _____

Date of last seizure _____ Length of seizure _____

Currently prescribed medications _____

☐ Other Health Conditions

☐ Cancer ☐ Heart condition (be specific) _____

☐ Hemophilia ☐ Sickle cell anemia ☐ Physical disability (be specific) _____

☐ Gastrointestinal Condition (be specific) _____

Other (explain) _____

Medication needed *IN SCHOOL* ☐ NO ☐ YES List medication(s) _____

Special procedures (e.g. catheterization, cardiac monitor, etc.) required *IN SCHOOL* ☐ NO ☐ YES

(explain) _____

☐ Vision Conditions

☐ Contacts ☐ Glasses ☐ Non Correctable

☐ Other _____

☐ Hearing Conditions

☐ Hearing aid(s) ☐ Non Correctable

☐ Other _____

☐ Physical Restrictions

Does your child's health condition restrict participation in Physical Education? ☐ NO ☐ YES

If Yes, please complete Physician's Referral for participation in Physical Education form (SS/SE-200).
http://www.fcps.edu/it/forms/se200.pdf

PART 3 School Public Health Nurse To Complete if parent or guardian indicates medical condition(s).

☐ Health condition noted

☐ Follow protocol (school health care emergencies–suggestion for temporary care manual)

☐ Medical flag

☐ Individual health care plan or procedure

_____ _____

Public Health Nurse Signature Date

Notes _____

_____

_____

Information from the Fairfax County Public Schools student scholastic record is released on the condition that the recipient agrees not to permit any other party to have access to such information without the written consent of the parent, guardian, or the eligible student.

RETURN COMPLETED FORM TO SCHOOL HEALTH ROOM AS SOON AS POSSIBLE

FAIRFAX COUNTY PUBLIC SCHOOLS

EMERGENCY CARE INFORMATION

In case of an emergency, the school staff will contact 911.
Every attempt will be made to contact a parent, a guardian, or a designated emergency contact.

STUDENT INFORMATION

Last:	First:	Middle:	Date of Birth:	Gender: ☐ M ☐ F	Grade:

School Name:	ID No.:	Teacher or Counselor :	Bus # (AM):	Bus # (PM):

☐ Student has medical alert information on file. See page 2 for details.

PARENT/GUARDIAN CONTACT INFORMATION

This form is to be completed by the enrolling parent. The enrolling parent is the natural or adoptive parent or legal guardian with whom the student lives the preponderance of the school week and who enrolled the student in school.

Enrolling Parent Last:	First:	Middle:	Telephone
			Home:
Number: Street:		Apt.#:	Work:
City:	State:	Zip:	Cell:
Relationship: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Self	☐ Resides with	Language:	E-mail:

Other Parent Last:	First:	Middle:	Telephone
			Home:
Number: Street:		Apt.#:	Work:
City:	State:	Zip:	Cell:
Relationship:	☐ Resides with	Language:	E-mail:

Other Parent Last:	First:	Middle:	Telephone
			Home:
Number: Street:		Apt.#:	Work:
City:	State:	Zip:	Cell:
Relationship:	☐ Resides with	Language:	E-mail:

Other Parent Last:	First:	Middle:	Telephone
			Home:
Number: Street:		Apt.#:	Work:
City:	State:	Zip:	Cell:
Relationship:	☐ Resides with	Language:	E-mail:

OTHER CONTACT INFORMATION

Please list at least two people we may call if the parent(s) or guardian(s) cannot be reached in the event of an emergency. These people also have your permission to pick your child up from school during the school day.

Name of Person	Relationship	Language	Telephone

* Please remember to sign page 2.

FAIRFAX COUNTY PUBLIC SCHOOLS

EMERGENCY CARE INFORMATION

In case of an emergency, the school staff will contact 911.
Every attempt will be made to contact a parent, a guardian, or a designated emergency contact.

STUDENT INFORMATION

Last:	First:	Middle:	Date of Birth:	Gender: ☐ M ☐ F	Grade:

School Name:	ID No.:	Teacher or Counselor:	Bus # (AM):	Bus # (PM):

Siblings attending the same school (complete if applicable).

Name(s): _____

Is Internet access available in your home for your child/children?

☐ Yes ☐ No ☐ Declined

CURRENT HEALTH CONDITIONS

Below check any current health condition that may require attention during the school day. **Also complete and submit Health Information form SS/SE-71 if your child has health conditions that require attention during the school day. See below for medical alert information currently on file.**

☐ allergies (be specific)
- ☐ foods _____
- ☐ medicines _____
- ☐ bee sting or insect bite _____
- ☐ other _____

☐ asthma
☐ cancer
☐ diabetes
☐ hearing problems ☐ hearing aid(s)
☐ heart problems (be specific) _____

_____

☐ hemophilia ☐ sickle cell anemia
☐ physical disability (be specific)

_____

☐ respiratory (be specific)

_____

☐ seizures
☐ vision problems (be specific) _____
- ☐ glasses ☐ contacts

☐ other (be specific)

_____

_____

List all medications and dosages your child receives on a continual basis:

_____

_____

_____

MEDICAL ALERT INFORMATION ON FILE

This space reserved for system printing of Health Information

PHYSICIAN INFORMATION

My child's medical care is provided by: _____ _____
(name of doctor, clinic, or HMO) (telephone)

Does your child have health insurance? ☐ Yes ☐ No

If yes, medical coverage is provided by: _____ _____
(health insurance company, assistance program, HMO, etc.) (telephone)

First aid and emergency treatment will be provided to students in accordance with the current version of FCPS Regulation 2102 or in accordance with the student's individualized health plan.

ENROLLING PARENT OR GUARDIAN SIGNATURE: _____ DATE: _____

FAIRFAX COUNTY PUBLIC SCHOOLS

Parent Information About the Emergency Care Information Form

What is the Emergency Care Information form used for?

School staff rely on the Emergency Care Information form to provide them with information needed to (1) contact a parent or other responsible adult in the event of an emergency concerning the student; (2) assist school staff or emergency medical services in the event the student requires medical services for illness or injury; (3) respond to requests to release of the student during the school day in nonemergency situations.

The contact information is also used to notify the parent/guardian through the FCPS Keep in Touch (KIT) notification system about emergency, delayed opening and school closing information, attendance, and outreach messages (this includes news and announcements from your child's school).

Who is responsible for completing the Emergency Care Information form?

This form should be completed by the enrolling parent. The enrolling parent is the natural parent, adoptive or legal guardian with whom the student lives the preponderance of the school week and who enrolled the student in school.

Who else should be listed in the Parent/Guardian Contact Information section of the form?

The Parent/Guardian Contact Information section has space for a student's other natural or adoptive parent or legal guardian to be listed. A parent's contact information should be listed in the second box if the parent shares legal custody of the child with the enrolling parent. School staff will share information about the student and will release the student to a parent who has legal custody of the child. A stepparent that resides with the child may also be listed in the Parent/ Guardian Contact Information section of the form.

Who should be listed in the Other Contact Information section of the form?

It is very important that school staff have contact information for at least two responsible adults who can be contacted in the event of an emergency when the parents cannot be reached. Other adult family members or friends should be listed in the Other Contact Information section of the form.

Please also note that school staff will allow any person you list on this form in the Other Contact Information section to pick up the child from school during the school day in both emergency and nonemergency situations.

In the event of an emergency, who will the school notify?

In the event of an emergency, school staff members will attempt to contact the enrolling parent first. If the enrolling parent cannot be reached, school staff will then attempt to reach the parent/guardian, if any. If neither the enrolling nor other parent/guardian listed can be reached, school staff shall contact the people listed in the Other Contact Information section on the Emergency Care Information form. Once a parent or designated contact is reached, staff will provide him or her with information about the student and the emergency situation and will release the student to him or her, as appropriate.

A noncustodial parent may be provided with information about the child, but staff will not release the student to him or her without the written consent of the custodial parent (Regulation 2240, III.B, and IV.F).

What should I do if I need to update the information on this form?

It is extremely important that school staff have the most up to date and accurate information about your child. The enrolling parent may update information on this form at any time by either contacting the school or accessing weCare@school in the FCPS 24-7 website (fcps.blackboard.com).

Where can I find more information about FCPS's procedures regarding the emergency care information form and first aid and emergency treatment for students?

Please refer to FCPS Regulation 2240, Parent Participation and Decision-making and FCPS Regulation 2102, First Aid, Emergency Treatment, and Administration of Medication for Students for additional information.

HOME LANGUAGE SURVEY

FCPS STAFF MEMBERS: This form must be completed for all students registering in Fairfax County Public Schools. Translations of this form are available on the FCPS intranet.

To Be Completed by Parent or Guardian:

Student Name _____ Date of Birth ____/____/____
Last First Middle Mo. Day Yr.

Parent(s) or Guardian(s)
Please answer the questions below accurately and completely. This information is necessary to provide the most appropriate placement and instruction for your child and will not be used for any other purposes. Thank you for your cooperation.

1. What was the first language that this student spoke? _____

2. Is there a language other than English spoken in the home? ☐ No ☐ Yes

   Which language(s)? _____

3. Does the student speak a language other than English? ☐ No ☐ Yes

   Which language(s)? _____

IN WHICH LANGUAGE DO YOU PREFER TO RECEIVE COMMUNICATION FROM THE SCHOOL?

_____

_____ ____/____/____ _____
Parent or Guardian Signature Mo. Day Yr. Print Name

To Be Completed by FCPS Staff Member:

DETERMINATION OF HOME LANGUAGE CODE

- If the answer to question 1 is English and questions 2 and 3 are answered No, then enter language code 01 (English) in the box "Home Language" on the student registration form.
- If a language other than English is indicated in any one or more of the answers, enter the appropriate language code in the box "Home Language" on the student registration form. Use the language codes listed in *http://www.fcps.edu/it/forms/se216.pdf*
- Students whose language code is other than 01 (English) should be referred to student registration for English language assessment. Students entering kindergarten whose language code is other than 01 (English) may be registered at their base school prior to the beginning of the school year. Language minority students entering kindergarten after the first day of school should be referred to a student registration site to complete registration and entry assessment.

This procedure meets federal requirements for identifying and assessing language minority students in order to provide appropriate instructional support services for those students found to be limited English proficient.

FAIRFAX COUNTY PUBLIC SCHOOLS
CRIMINAL CONVICTION AND JUVENILE DELINQUENCY ADJUDICATION AFFIRMATION

Section 22.1-3.2 of the Code of Virginia requires that parents/guardians provide upon registration of students in public schools:

> **A sworn statement or affirmation indicating whether the student has been found guilty of or adjudicated delinquent for any offense listed in subsection G of Section 16.1-260 or any substantially similar offense under the laws of any state, the District of Columbia, or the United States or its territories.**

These offenses are:

- **A firearm offense**
- **Homicide**
- **Felonious assault and bodily wounding**
- **Criminal sexual assault**
- **Manufacture, sale, gift, distribution or possession of Schedule I or II controlled substances**
- **Manufacture, sale or distribution of marijuana**
- **Arson and related crimes**
- **Burglary and related offenses**
- **Robbery**
- **Prohibited street gang participation**
- **Prohibited street gang activity**
- **Recruitment of other juveniles for criminal street gang activity**

Student Name _____ **Date of Birth** _____

Parent/Guardian Affirmation

☐ I affirm that the above student **has not been** found guilty of or adjudicated delinquent for an offense listed above or any substantially similar offense under the laws of any state, the District of Columbia, or the United States or its territories.

☐ I affirm that the above registered student **has been** found guilty of or adjudicated delinquent for an offense listed above or any substantially similar offense under the laws of any state, the District of Columbia, or the United States or its territories, as indicated below:

_____	_____	_____
Type of Offense	Date of Offense	Jurisdiction Where Offense Occurred

Parent Signature	**Date**	**Print Parent Name**
_____	_____	_____

SS/SE-219 (11/06)

REGISTRAR: DO NOT RETAIN IN CUM FOLDER. MAINTAIN ALL COMPLETED FORMS TOGETHER IN SEPARATE CONFIDENTIAL FILE. IF PARENT/GUARDIAN CHECKS SECOND STATEMENT, NOTIFY BUILDING ADMINISTRATOR, WHO MAY INITIATE REFERRAL TO FCPS HEARINGS OFFICE.

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization

Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no longer than one year before your child's entry into school.

Name of School: _____ Current Grade: _____

Student's Name: _____
Last First Middle

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

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

Name of 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: _____-_____-_____

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

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

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

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

Please provide the following information:

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

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

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

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

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

Signature of Interpreter: _____Date: _____/_____/_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

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

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

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

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

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

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

Student's Name:_____Date of Birth: |____ |_ ___|___ _|

Section II
Conditional Enrollment and Exemptions

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

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

_____

_____

_____.

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

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

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

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

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

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

Section III
Requirements

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

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

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

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

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

Health Assessment

Date of Assessment: _____/_____/_____

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

Body Mass Index (BMI): _____ BP_____

❑ Age / gender appropriate history completed

❑ Anticipatory guidance provided

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	□	□	□

TB Screening: □ 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: □ Positive □ Negative
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.

	1000	2000	4000
R			
L			

❑ Screened by OAE (Otoacoustic Emissions): □ Pass □ Refer

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

□ Permanent Hearing Loss Previously identified: ___Left ___Right

□ Hearing aid or other assistive device

Vision Screen

❑ With Corrective Lenses (check if yes)

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

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

Dental Screen

❑ Problem Identified: Referred for treatment

❑ No Problem: Referred for prevention

❑ No Referral: Already receiving dental care

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

Summary of Findings (check one):
□ **Well child; no conditions identified of concern to school program activities**
□ **Conditions identified that are important to schooling or physical activity** (complete sections below and/or explain here): _____
_____

___ **Allergy** □ food: _____ □ insect: _____ □ medicine: _____ □ other: _____
Type of allergic reaction: □ anaphylaxis □ local reaction Response required: □ none □ 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:** _____

REQUEST FOR STUDENT RECORDS

To: Name of School Last Attended_____

Address of School_____

_____

_____

_____

Student Name: Last	First	Middle	Date of Birth

Please forward all records for the above student to include, but not limited to, academic, discipline, health, legal, test, and special services. Also, include marks interpretation, special clinical or diagnostic studies, and any other information that may be helpful.

To: Name of FCPS_____

Address of FCPS_____

_____

_____

_____ _____

Parent/Guardian or School Official Signature Date

Parental permission is not required when records are requested by authorized school personnel.
(Family Educational Rights and Privacy Act, Final Rule on Education Records,
Federal Register, June 17, 1976, Vol. 41, No. 18, page 24673).

Information from the Fairfax County Public Schools student scholastic record is released on the condition that the recipient agrees not to permit any other party to have access to such information without the written consent of the parent or of the eligible student.