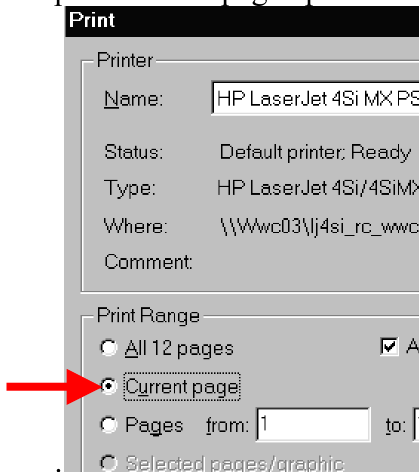
For students enrolling or re-enrolling in Fairfax County Public Schools

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



.

The forms included in this package are:

All enrolling (re-enrolling) students
Student Registration
Emergency Care Information
Health Information (two pages)
Acceptable use for Network Access (two pages)
Home Language Survey
State Health Form MCH-213 (four pages)
Request for Student Records

Use Only if needed
Guidance and Counseling Notice to Parents
Medication Authorization
Epi -Pen Authorization
Inhaler Authorization
Administration of Medication Information

Student Registration Form
Part A

FAIRFAX COUNTY PUBLIC SCHOOLS

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)		Gender	Grade Level
		☐ unlisted		☐ Male ☐ Female	

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.

Student Registration Form Part B

	Last	First	Middle
Student Legal Name			

FCPS Student ID

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 ☐ 2 ☐ 4 or more ☐ 1 ☐ 3	☐ Yes ☐ No Previous ID ____________	☐ Yes ☐ No		

Last School Attended NOT in FCPS

School Name

School Phone (ten digits)

Street City State Zip Code

School Fax (ten digits)

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

☐ 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	
				Placement Code	Base School
Birth Certificate Number ____________ Affidavit with Supporting Documentation Code ________	________ E ________ R ________				

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.

HEALTH INFORMATION

Complete this form annually to inform us about your student's health condition that affects his or her school day

This form is necessary to inform the Public Health Nurse (PHN) of your student's health status and to plan for health needs that may impact his/her school day. Information is only shared with required school staff as needed. Information provided on this form is protected by the Family Educational Rights and Privacy Act (FERPA) as part of the student's educational record and is securely stored in the health room. For any changes to your student's health condition during the school year or questions regarding this form, please contact the PHN through the health room at your child's school. Contact your child's school front office staff and ask to be connected with the health room.

Student Name: Last	**First**	**Middle**

School Year	**Grade**	**Gender:** ☐ Male ☐ Female	**Date of Birth**:	**New FCPS Enrollment:** ☐ Yes ☐ No

Parent/Legal Guardian Name:	**Contact Number Home:**	**Contact Number Cell:**	**Contact Number Work:**
1.	**1.**	**1.**	**1.**
Parent/Legal Guardian Name: 2.	**Contact Number Home: 2.**	**Contact Number Cell: 2.**	**Contact Number Work: 2.**

Allergies	**Yes**	**No**	For all allergies included	1. Name of allergies 2. Symptoms of reaction 3. Date of last reaction
Food				
Food Intolerance				
Latex				
Insect Sting				
Environmental				

For all health conditions checked **YES below,** in the **Comments** section:

1. Describe the health condition and any changes occurring over the past year, If **NO Change** indicate by checking that column
2. Provide the date of last Physician, Therapist, or other healthcare provider visit in the column under **Date of Last Provider Visit**

Health Conditions	**Yes**	**No**	**Comments**	No Change	Date of Last Provider Visit
ADD/ADHD					
Asthma			Date of last hospitalization/Emergency Room Visit		
Anxiety					
Breathing Problems					
Bladder/Kidney					
Blood Disorder					
Cancer					
Dental Problems					
Depression					
Diabetes			Date of last visit to Endocrinologist/Physician	Insulin	Other
Type 1				☐Syringe ☐Pen ☐Pump	
Type 2					

SS/SE-71 (5/17)

(OVER)

Fairfax County PUBLIC SCHOOLS
ENGAGE • INSPIRE • THRIVE

HEALTH INFORMATION

Complete this form annually to inform us about your student's health condition that affects his or her school day

Health Conditions	YES	NO	Comments	NO Change	Date of Last Provider Visit (MM/YY)
Eating Disorders					
Headaches					
Hearing Impairment					
Heart					
Neurological					
Muscle/Bones/Joint					
Seizures			Type & Date of last seizure:		
Skin Condition					
Stomach/Bowels					
Visual Impairment			☐ Glasses ☐ Contacts		
Other Please identify:					

If your child needs **medication** in school, please complete the Medication Authorization with indicated physician signatures, found at https://www.fcps.edu/registration/forms

Does your child require any health procedures or need any special equipment during the school day?
https://www.fcps.edu/sites/default/files/media/forms/se180.pdf ☐ Yes ☐ No

If Yes, please describe ____________________

Does your child's health condition restrict participation in Physical Education (P.E.)? ☐ Yes ☐ No
If yes, please have your physician complete the Physical Education form (SS/SE-200) for participation in P.E.
https://www.fcps.edu/sites/default/files/media/forms/se200.pdf

Parental Consent: I agree to allow school and health department staff to discuss information contained in this form with my child's healthcare provider.

Primary Care Provider(s) ____________ Phone Number(s) ____________

Parent/Guardian Name (Print) ____________ Parent/Guardian Signature ____________ Date ____________

Parent or guardian is responsible for providing the school with any medication, special food or equipment that the student may require during the day. Medication and Procedure Authorization forms are available at https://www.fcps.edu/registration/forms or obtained at the school health room.

School Public Health Nurse to Complete

☐ Health Information Form Reviewed

☐ Follow protocol (School Health Care Emergencies-Suggestion for Temporary Care)

☐ Medical flag ☐ Action plan or procedure

Public Health Nurse Name ____________ Public Health Nurse Signature ____________ Date ____________

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.		Student Cell ________________________			

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.

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): ____________________

Name(s): ____________________

Primary Internet access in the home for this student is

☐ Cellular ☐ Broadband ☐ Other ☐ None ☐ Declined

Do you have a device for this student to use that meets their educational needs? ☐ Yes ☐ No ☐ Declined

CURRENT HEALTH CONDITIONS

Below check any current health condition(s) that EMS or an emergency room physician should know about health of your student. **Also complete and submit Health Information form SS/SE-71 if your child has a health condition(s) that require(s) 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

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: ____________________

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.

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.

How do I change the phone number used for attendance and non-emergency calls?
Changes to the phone number used for attendance and non-emergency calls can only be made by contacting your child's school directly and specifying that you wish to have the student home phone number changed.

HOME LANGUAGE SURVEY

Student Name ____ Date of Birth ____________
Last First Middle

Parent(s) or Guardian(s): Federal guidelines require school divisions to identify students who are potential English learners (ELs). If the answers to the following questions indicate that a language other than, or in addition to, English is spoken in the home, the student's English language proficiency will be evaluated to ensure that services are offered to students who need them. Based on the results of these assessments, students are found English proficient or eligible for ESOL services.

Please answer the questions completely and accurately.

1. What is the primary language used in the home, regardless of the language spoken by the student?

   Which language? ________________________________

2. What is the language most often spoken by the student?

   Which language? ________________________________

3. What is the language that the student first acquired?

   Which language? ________________________________

In which language do you prefer to receive communication from the school?

Which language? ________________________________

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

FCPS Staff Members: This form must be completed for all students registering in Fairfax County Public Schools. It should be the first document provided to parent(s)/guardian(s) during the registration process. If there is a language other than, or in addition to, English indicated for any of the three questions, enter this language in the student information system. Please make sure that all questions are answered completely.

Students with a language other than, or in addition to, English should be referred to student registration for registration and assessment. Students entering kindergarten with a language, other than or in addition to, English may be registered at their base school prior to the beginning of the school year. Starting on the first day of school, kindergarten students with a language other than, or in addition to, English should be referred to student registration for registration and assessment.

If the parent(s)/guardian(s) have a question about this form, please refer them to a school administrator or contact the ESOL Assessment Center at 703-204-4375.

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:** ____

Identification of Military Connected Students

In accordance with the Code of Virginia (§22.1-287.04), local school divisions are required to identify students who have a parent in the United States uniformed services. Completing this form allows Virginia localities to maintain reliable and accurate data for potential grant funding and to receive services to meet the needs of uniformed services- connected students.

Student Name ____ **Student Date of Birth** ___________

Definition of Military Connected:

- **United States Active Duty Forces:** Includes Army, Navy, Air Force, Marine Corps, Coast Guard, the Commissioned Corps of the National Oceanic and Atmospheric Administration, or the Commissioned Corps of the U.S. Public Health Services.
- **United States Reserve Forces:** Includes Army, Navy, Air Force, Marine Corps, or Coast Guard.
- **National Guard:** Includes active or reserve.

Continuing FCPS students: Has the parent's military connected status changed in the last school year since you previously completed this form?

☐ **No** If NO, stop here. You do not need to return this form.

☐ **Yes** If YES, please indicate current status and return this form.

CHECK ONE:

☐ Parent is a member of the United States Active Duty Forces.
☐ Parent is a member of the United States Reserve Forces.
☐ Parent is a member of the National Guard.
☐ Parent is no longer a member of the United States uniformed services.

Newly enrolling students: Does the student have a parent in the United States uniformed services?

☐ **No** If NO, stop here. You do not need to return this form.

☐ **Yes** If YES, please indicate current status and return this form.

CHECK ONE:

☐ Parent is a member of the United States Active Duty Forces.
☐ Parent is a member of the United States Reserve Forces.
☐ Parent is a member of the National Guard.

Parent/Legal Guardian Name ____

Parent/Legal Guardian Signature ____ Date ______________

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.

SS/SE-75 (8/97)