



# Virginia Preschool Initiative (VPI) Preschool Registration Checklist



The parent/legal guardian must provide ALL of the following documents during the registration process.

## 1. REGISTRATION FORMS:

- |   |  |
|---|--|
| <input type="checkbox"/> Home Language Survey                     | <input type="checkbox"/> Student Health Information Form |
| <input type="checkbox"/> Student Registration Form                | <input type="checkbox"/> Student-Parent Survey           |
| <input type="checkbox"/> Residency Verification & Enrollment Form | <input type="checkbox"/> ACPS Signature Form             |

Please complete the online forms using this link: [www.acps.k12.va.us/Page/3073](http://www.acps.k12.va.us/Page/3073)

## 2. IDENTIFICATION:

- ☐ Child's original birth certificate or a certified birth certificate (your child must be 3 or 4 years old by September 30)
- ☐ Original Parent/Legal Guardian ID (Proof that the adult registering the child is the Parent/Legal Guardian)  
The name on the birth certificate should match the parent/guardian's picture ID or court documents of legal custody.

## 3. MEDICAL DOCUMENTS:

- ☐ **Commonwealth of Virginia School Entrance Health Form**
- ☐ **Physical Examination Report** State law (Ref. Code of Virginia § 22.1-270) requires that your child receives a comprehensive physical examination in the United States before entering preschool in a public elementary school. The physical examination must be dated within one year prior to the date of entry into preschool.
- ☐ **Negative Tuberculosis Risk Assessment, PPD Tuberculin Skin Test, or negative Chest X-Ray, completed in the United States** and Administered within 12 months prior to the child's first day of school.
- ☐ **Immunization Records (Documenting month, day and year each was administered)**
  - (4 doses) Diphtheria, Tetanus, Pertussis (Dtap, DTP or Tdap)
  - (3 doses) POLIO (OPV or IPV)
  - (3 doses) HEPATITIS B
  - (2 doses) Hepatitis A Vaccine (HAV)
  - (1 dose) Measles, Mumps, & Rubella (MMR)
  - (1 dose) Varicella (Chicken Pox)
  - (1 dose) Haemophilus Influenzae (HIB)
  - (1 dose) Pneumococcal Vaccine (PCV)

IMPORTANT IF IMMUNIZATIONS ARE DEFICIENT: If new vaccines have just been administered, a licensed health care provider must advise in writing the date of the next scheduled visit for additional vaccines. Also, proper spacing of doses should be followed. When additional vaccines are received, written documentation needs to be provided to the school nurse. Students who fail to complete immunizations by date assigned will be excluded from school.



# Virginia Preschool Initiative (VPI) Preschool Registration Checklist



## 4. INCOME VERIFICATION:

Please supply the following recent documents (select all that apply to your family):

- |   |  |
|---|--|
| <input type="checkbox"/> Income Tax Form 1040                           | <input type="checkbox"/> Income from estate and trust                                    |
| <input type="checkbox"/> W-2  | <input type="checkbox"/> Rents and royalties   |
| <input type="checkbox"/> 2 recent pay stubs (within 30 days)            | <input type="checkbox"/> Pension or retirement income                                    |
| <input type="checkbox"/> Unemployment and workers' compensations        | <input type="checkbox"/> Veterans' benefit payment                                       |
| <input type="checkbox"/> Supplemental Security Income (SSI)             | <input type="checkbox"/> Foster Care Reimbursement                                       |
| <input type="checkbox"/> Temporary Assistance for Needy Families (TANF) | <input type="checkbox"/> Financial assistance from outside the household                 |
| <input type="checkbox"/> Supplement Nutrition Assistance Program (SNAP) | <input type="checkbox"/> VPI Declaration of No Income or No Documentation of Income Form |
| <input type="checkbox"/> Income from education assistance               |  |
| <input type="checkbox"/> Alimony and child support                      |  |

## 5. RESIDENCY VERIFICATION:

Registering adult must provide the following documents: All documents must be the original copy (current-within the past 60 days) & clearly notes the parent/legal guardian name & Alexandria City address.

### ☐ CATEGORY A – MUST SELECT ONE (1) DOCUMENT:

- **Full Lease or Rental Agreement:** The original lease must be current (not expired) indicating the dates, names and property address for the parent/legal guardian who is enrolling the student. If the lease is a private generated agreement with the landlord the lease must be notarized.
  - If your lease agreement is expired and cannot be renewed, then you MUST submit BOTH the full expired lease agreement AND a recent (within 60 days) letter signed by your leasing office *stating your lease is now on a month-to-month basis*. The letter must be signed on company letterhead or notarized including the date, parent/legal guardian's name, and address.
- **Mortgage:** The resident may present a mortgage bill prepared by the lender (including date, Alexandria address and lender name) within 60 days of registration or the initial mortgage contract with the current copy of the owner's property tax.
- **Deed:** The property deed must be accompanied by a copy of the owner's personal property tax.

### ☐ CATEGORY B - MUST SELECT TWO (2) SUPPORTING DOCUMENTS:

- Utility bill (water, gas, electric, internet, cable and/or landline phone bill). The bill must be dated within the past 60 days. If all utilities are covered in your leasing contract and you do not have any other bills please provide a letter from your property manager on company letterhead that notes water, gas, sewer, electric are all included in the monthly rent.
- Mailed letter from a government agency (SNAP, TANIF, Medicaid, HUD, ARHA, IRS, etc.)
- Current pay stub (noting Alexandria address & Virginia tax withholding)
- 2 consecutive bank statements mailed to the Alexandria City address
- Latest federal/state income tax return noting the City of Alexandria address
- Current homeowner or renter's insurance policy noting the City of Alexandria address
- Family is new (less than 30 days) to the City of Alexandria. Due 30 days after registration

### ☐ SHARED HOUSING RESIDENTS:

- If the parent/legal guardian is living with someone else (and the lease, deed, or mortgage is not in the parent/legal guardian's name), you MUST complete a notarized [Shared Housing Form A/B \(PDF\)](#) and attach the original copy of the lease, deed, or mortgage of the person with whom you reside. Additionally, the parent/legal guardian is required to provide two supporting documents (in the parent/legal guardian's name) as listed above.

\*\*\*\* ALL of the following documents must be provided during the registration process. \*\*\*\*

## Home Language Survey

**Parent/Guardian:** Federal regulations require school systems to survey all enrolling students regarding the students' home language and any other languages the students may speak. Based on the information provided below, the student may be assessed for English proficiency as required by federal regulations. Based on the results of the assessment, the student may be eligible for supplemental instruction through the English Learner (EL) program. Parents/guardians will be informed about the assessment results and if the student is eligible for supplemental services, the parents will have the opportunity to accept or refuse the supplemental EL services.

**Padre, madre o tutor legal:** Las leyes federales requieren que los sistemas escolares encuesten a todos los alumnos sobre el idioma que se habla en el hogar y sobre cualquier otro idioma que puedan hablar los alumnos. Con base en la información proporcionada a continuación, el alumno pudiera ser evaluado para determinar su competencia en el idioma inglés tal como lo exigen las normas federales. Con base en los resultados de la evaluación, el alumno pudiera ser elegible para recibir instrucción suplementaria mediante el programa de Aprendizaje del Idioma Inglés (EL). Se informará a los padres o tutores legales sobre los resultados de la evaluación y si el alumno es elegible para recibir servicios suplementarios, los padres tendrán la oportunidad de aceptar o rechazar los servicios suplementarios de EL.

ወላጅ/ አሳዳጊ፡ አዲስ የሚመዘገቡ ተማሪዎች በቤታቸው ስለሚናገሩት ቋንቋ እና ተማሪው ስለሚናገረው ሌላ ቋንቋ የትምህርት ቤት አስተዳደሮች መጠይቅ እንዲያዘጋጁ የፌዴራል ሕግ ይጠይቃል። ኢትዮጵያ በተገለፀው መረጃ ላይ ተመስርቶ የፌዴራል ሕግ በሚጠይቀው መሰረት የተማሪውን የእንግሊዘኛ ቋንቋ ብቃት ምዘና ይካሄዳል። ከሚካሄደው ምዘና በሚገኘው ውጤት መሰረት ተማሪው በእንግሊዘኛ ቋንቋ ትምህርት (ኢ.ኤል) ፕሮግራም ተጨማሪ የቋንቋ ትምህርት ለመውሰድ ብቁ ሊሆን ይችላል። ወላጆች/ አሳዳጊዎች ስለምዘና ውጤት እና ተማሪው ለተጨማሪ ድጋፍ አገልግሎት ብቁ ስለመሆኑ መረጃ የሚደርሳቸው ሲሆን ወላጆችም በተጨማሪነት የሚሰጠውን የኢ.ኤል አገልግሎት የመቀበል ወይም ያለመቀበል እድል ያገኛሉ።

ولي أمر الطالب/الوصي الشرعي: تتطلب اللوائح الفيدرالية قيام الأنظمة التعليمية بإجراء استبيان لجميع الطلاب المسجلين فيما يتعلق باللغة المستخدمة في منزل الطالب وأية لغات أخرى قد يتحدثها الطلاب. وعلى ضوء المعلومات المقدمة أدناه، يمكن تقييم كفاءة الطالب في اللغة الإنجليزية وكما هو مطلوب بموجب اللوائح الفيدرالية. واستناداً إلى نتائج التقييم، قد يكون الطالب مؤهلاً للحصول على خدمات تكميلية، حيث ستتاح لأولياء الأمور فرصة قبول أو رفض تلقي خدمات EL التكميلية. الأمور/ الأوصياء الشرعيون بنتائج التقييم وفيما إذا كان الطالب مؤهلاً للحصول على خدمات تكميلية، حيث ستتاح لأولياء الأمور فرصة قبول أو رفض تلقي خدمات EL التكميلية.

والدين/ سرپرست: مقررات حکومت فدرال مکاتب را ملزم میسازد تا کلیه شاگردان ثبت نام شده را در مورد زبان خانگی متعلمین و هر زبان دیگری که ممکن است صحبت کنند، بررسی کنند. براساس اطلاعات ارائه شده در زیر، شاگرد ممکن است برای مهارت لسان انگلیسی مطابق مقررات فدرال ارزیابی شود. براساس نتایج ارزیابی، دانش آموز ممکن است واجد شرایط آموزش تکمیلی از طریق برنامه تعلیم انگلیسی (EL) باشد. والدین/سرپرستان از نتایج ارزیابی مطلع می شوند و اگر شاگرد واجد شرایط خدمات تکمیلی باشد، والدین این فرصت را دارند که خدمات آموزش انگلیسی EL را بپذیرند یا امتناع کنند.

Student Name: _____	Date of Birth: _____
Nombre del alumno	Fecha de nacimiento
የተማሪው ስም	የትውልድ ቀን፤
اسم الطالب	تاريخ الميلاد
اسم شاگرد	تاريخ تولد
Parent/Guardian Name: _____	Telephone: _____
Nombre del padre, madre o tutor legal	Teléfono
የወላጅ/አሳዳጊ ስም	ስልክ
اسم ولي الأمر / الوصي الشرعي	رقم الهاتف
اسم والدین/ سرپرست	تيليفون

1. What is the primary language used in the home, regardless of the language spoken by the student? \_\_\_\_\_  
 ¿Cuál es el idioma principalmente utilizado en el hogar, independientemente del idioma que el alumno hable?

በቤት ውስጥ የሚነገር የመጀመሪያ ዋነኛ ቋንቋ ምንድን ነው ተማሪው ሌላ ቋንቋ የሚናገር ቢሆንም እንኝ?

ماهي اللغة الأساسية المستخدمة في البيت، بغض النظر عن اللغة التي يتحدث بها الطالب؟  
 بدون توجه به زبانی که شاگرد صحبت میکند، زبان اصلی مورد استفاده در خانه، چیست؟

2. What is the language most often spoken by the student? \_\_\_\_\_  
 ¿Cuál es el idioma que el alumno habla con más frecuencia?

ተማሪው ብዙ ጊዜ የሚናገረው ቋንቋ ምንድን ነው?

ماهي اللغة التي يتحدث بها الطالب غالباً؟  
 زبانی که اغلب شاگرد صحبت میکند، چیست؟

3. What is the language that the student first acquired? \_\_\_\_\_  
 ¿Cuál es el idioma que el alumno aprendió primero?

የተማሪው የአፍ መፍቻ ቋንቋ ምንድን ነው?

ماهي اللغة التي تعلمها الطالب لأول مرة؟  
 زبانی که شاگرد برای اولین بار صحبت نمود، چیست؟

In which language do you prefer to receive communication from the school? ☐ English ☐ Español ☐ አማርኛ ☐ العربية ☐ دیگر

¿En qué idioma prefiere recibir comunicación de la escuela?

ከትምህርት ቤት የሚለከውን መረጃ መለዋወጫ መገናኛ እንዲሆን የትኛው ቋንቋ ይመርጣሉ?

ماهي اللغة التي تفضل التواصل بها مع المدرسة؟  
 در کدام زبان ترجیح می دهید با مکتب ارتباط برقرار کنید؟

☐ Other: \_\_\_\_\_  
 Otro  
 ሌላ  
 أخرى  
 دیگر

Parent/Guardian Signature: _____	Date: _____
Firma del padre, madre o tutor legal	Fecha
የወላጅ/አሳዳጊ ፊርማ	ቀን
توقيع ولي الأمر/الوصي الشرعي	التاريخ
امضای والدین/ سرپرست	تاریخ

**ACPS Staff Members:** This form must be completed for all students registering in Alexandria City Public Schools. It should be the first document provided to the parent/guardian during the registration process. Please ensure that all questions are answered completely.

If a language other than, or in addition to, English is listed in response to question 1, 2, or 3, the student should be referred to the Office of English Learner Services (EL Office) for registration and assessment. Families and staff can contact the EL Office at 703-619-8022 with any questions. Rev. 8/8/18



# STUDENT REGISTRATION FORM • Alexandria City Public Schools

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## STUDENT INFORMATION

Student's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Student and Primary Parent/Guardian Address: Street \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth: Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_ Country of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Gender: ☐ Male ☐ Female Gender Identity: ☐ Male ☐ Female ☐ Other Preferred Name: \_\_\_\_\_

(For students whose legal name does not reflect their Gender Identity. Not for nicknames.)

Is this student Hispanic or Latino? (choose only one)

- ☐ No, not Hispanic or Latino ☐ Yes, Hispanic or Latino (person of Cuban, Mexican, Puerto Rican, South American, Central American, or other Spanish culture or origin, regardless of race)

What is the student's race? (choose one or more)

- ☐ American Indian/Alaskan ☐ Black or African American ☐ White (a person having origins in any of the original peoples of Europe, the Middle East or North Africa)  
☐ Asian ☐ Native Hawaiian or Other Pacific Islander

Last School Attended: \_\_\_\_\_ ☐ Public ☐ Private

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If not an Alexandria City school, has student EVER attended Alexandria City Public Schools? ☐ Yes ☐ No

If Yes, please provide the following: School: \_\_\_\_\_ Year: \_\_\_\_\_ Grade: \_\_\_\_\_

## PARENT/GUARDIAN INFORMATION

Primary Parent/Guardian:

*This is the parent/legal guardian with whom the student lives most of the week, and the main contact regarding the student.*

Do you live/reside in the City of Alexandria? ☐ Yes ☐ No If No, has an exception to policy been approved? ☐ Yes ☐ No

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ ☐ Male ☐ Female

- ☐ Father ☐ Stepfather ☐ Legal Guardian  
☐ Mother ☐ Stepmother ☐ Foster Parent

Other (please indicate relationship): \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Is your home phone a cell phone? ☐ Yes

☐ No

Cell Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_

Work Address: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Ext: \_\_\_\_

Parent/Guardian's preferred language of communication?

- ☐ English ☐ Spanish ☐ Amharic ☐ Arabic ☐ Dari ☐ Other (please specify) \_\_\_\_\_

Parent/Guardian #2:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ ☐ Male ☐ Female

- ☐ Father ☐ Stepfather ☐ Legal Guardian  
☐ Mother ☐ Stepmother ☐ Foster Parent

Other (please indicate relationship): \_\_\_\_\_

Address: ☐ Address is the same as student and primary parent/guardian's address above

Street \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Is your home phone a cell phone? ☐ Yes

☐ No

Cell Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_

Work Address: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Ext: \_\_\_\_

**STUDENT BACKGROUND**

Does your child have a current IEP for Special Education services or 504 Plan? ☐ Yes ☐ No

If Yes, has documentation been provided to the school? ☐ Yes ☐ No

Has your child been expelled from attending school 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? ☐ Yes ☐ No

**STUDENT'S SIBLINGS**

Name	Birth Date	Sex	School
1.			
2.			
3.			
4.			
5.			

**EMERGENCY CONTACTS**

Please list at least two people we may call to make emergency decisions and/or pick up your child from school if the parent(s)/guardian(s) cannot be reached in the event of an emergency:

**Emergency Contact #1 (Other than Parent/Guardian):**

Name: \_\_\_\_\_

Address: Street \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

**Emergency Contact #2 (Other than Parent/Guardian):**

Name: \_\_\_\_\_

Address: Street \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

**Emergency Contact #3 (Other than Parent/Guardian):**

Name: \_\_\_\_\_

Address: Street \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

**PRE-KINDERGARTEN EXPERIENCE**

Only for students enrolling into kindergarten

**During the year before kindergarten, my child attended (choose one):**

Virginia Preschool Initiative (VPI) 4-year-old program at:

- ☐ Alexandria City Public Schools (ACPS)  
☐ Campagna Center  
☐ Child and Family Network Center (CFNC)  
☐ Creative Play School  
☐ Hopkins House-Helen Day Preschool Academy

Another pre-K program:

- ☐ Early Childhood Special Education  
☐ Preschoolers Learning Together (PLT)  
☐ Head Start  
☐ Full-day Private Preschool/Daycare  
☐ Half-day Private Preschool  
☐ Licensed Family Home Daycare Provider  
☐ Department of Defense Child Development Program

Other:

- ☐ Parent/Relative  
☐ Child care provider in my home (nanny, au pair, etc.)  
☐ Other:  
Specify: \_\_\_\_\_

By signing this form I am verifying that the information contained herein is correct.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR OFFICE USE ONLY**

Student ID	School ID	Sch/Res	Att/Permit Code	Address/Transfer Permit Verified	Grade	Entry Code	Entry Date	Office Verification/Signature

# Residency Verification & Enrollment Form



## Part I : Student/Family Information

Please complete A, B or C.

- A. I am the Parent who is enrolling \_\_\_\_\_ in school.  
(student full name)
- B. I am the Legal Guardian/Primary Caregiver enrolling \_\_\_\_\_ in school (must provide official documentation).  
(student full name)
- C. I am the adult student (18 years or older) enrolling myself, \_\_\_\_\_ in school.  
(student full name)

I, the parent/legal guardian/caregiver and/or adult student, affirm that I/we reside at the following domicile\*:

Full Address:

\_\_\_\_\_  
Street name      Apt. #      City      State      Zip Code      Phone Number

## Part II: Parent/Guardian/Caregiver or Adult Student Sworn Statement

I understand that enrollment of the student in Alexandria City Public Schools is based on my affirmation that I am (Part I) the parent/legal guardian of the student and a resident of the City of Alexandria, (Part II) this sworn statement of City of Alexandria residency and (Part III) my presentation of residency verification documentation (see page 3 - category A, B, or C). I affirm I reside with the student at the address noted in this document. If this sworn statement is false, I understand that I may be liable for payment of retro-tuition for the student, and that the student will be withdrawn from Alexandria City Public Schools. Please be advised that according to the Code of Virginia § 22.1-264.1, it is a Class 4 misdemeanor to knowingly misrepresent residency for the purpose of enrollment in a school outside the attendance zone in which the student resides. I hereby waive my rights to confidentiality of information relative to my residence and understand that the Alexandria City Public Schools will use whatever legal means it has at its disposal to verify my residence. I also agree to notify the school of any change of residence for myself and/or the student with in three (3) business days of such change.

\_\_\_\_\_  
Printed Name of Parent/Legal Guardian/Caregiver or Adult Student

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Signature of Parent/Legal Guardian/Caregiver or Adult Student

\_\_\_\_\_  
Date

\*A bona fide residence/domicile is defined as where a person lays their head each night. Owning or renting a property is not enough to claim residency in the City of Alexandria. The student and legal guardian must sleep in the City of Alexandria nightly.

\*\*\* ACPS STAFF OFFICAL USE ONLY - DO NOT COMPLETE BELOW THIS LINE\*\*\*

### Part III: Residency Verification

Registering adult must provide photo identification, student birth certificate & the following three (3) documents: All documents must be the original copy (current-within the past 60 days) & clearly notes the parent/legal guardian or adult student name & Alexandria City address. See reverse for further explanation of documents.

**Category A – one (1) document:**

- ☐ Lease Agreement
- ☐ Deed (with copy of property tax)
- ☐ Mortgage contract

**Category C:**

- ☐ Lack of Housing
- ☐ DSS/Foster Care Services

**Category B - two (2) supporting documents:**

- ☐ Utility bill (water, gas, electric, cable, and/or landline phone)
- ☐ Current personal Alexandria City property tax bill/receipt
- ☐ Mailed letter from a government agency (TANIF, HUD, ARHA, IRS, etc.)
- ☐ Current pay stub (noting Alexandria address & Virginia tax withholding)
- ☐ 2 consecutive bank statements (mailed)
- ☐ Latest federal/state income tax return noting the city of Alexandria address
- ☐ Current homeowner or renter's insurance policy noting the City of Alexandria address
- ☐ Family is new (less than 30 days) to the City of Alexandria. Due \_\_\_\_\_

**Shared Housing Residents:** If the parent/guardian is living in a shared housing a notarized A/B form will be required with a copy of the homeowner's mortgage, Deed or a copy of the lease with whom the student and parent are living. Additionally, you will be required to provide two supporting documents (in the parent/legal guardian's name) as listed above. A home visit maybe completed in cases of questionable residency. **A/B FORM EXPIRATION:** \_\_\_\_\_ (Registrar - enter date into PowerSchool).

**I certify that I personally reviewed all the documents presented and affirm that the information represented above is true and factual to the best of my knowledge, information, and belief. I also affirm that copies of all required documentation will be attached to this document and placed in the student's file.**

School Official Name (Print)

School Official (Signature)

Date



# List of Acceptable Residency Verification Documentation

All documents must note the registering parent/legal guardian or adult student's full name and Alexandria City address

## Category A: (One document from this list to verify residency)

- ☐ Lease or Rental Agreement: The original lease must be current (not expired) indicating the dates, names and property address for the parent/legal guardian who is enrolling the student. If the lease is a private generated agreement with the landlord the lease must be notarized.
- ☐ Deed: The property deed must be accompanied by a copy of the owner's personal property tax. This may be obtained (free of charge) at <http://realestate.alexandriava.gov/index.php?action=address>. The deed must be in the parent/legal guardian name.
- ☐ Mortgage: The resident may present a mortgage bill prepared by the lender (including date, Alexandria address and lender name) within 60 days of registration or the initial mortgage contract with current copy of the owner's property tax. This may be obtained for free at <http://realestate.alexandriava.gov/index.php?action=address>
- ☐ I am living in shared housing and the lease/deed or mortgage is not in my name. Please complete a Shared Housing (A/B) Form and attach the lease/deed or mortgage of the person with whom you reside.

**AND**

## Category B: (Two documents from this list to verify residency)

- ☐ Utility bill (water, gas, electric, cable and/or landline phone bill). The bill must be dated within the past 30 days. If all utilities are covered in your leasing contract and you do not have any other bills please provide a letter from your property manager on company letter head that notes water, gas, sewer, electric are all included in the monthly rent.
- ☐ Current Alexandria City Personal Property Tax (vehicle, RV, boat). Please note: Virginia Department of Motor Vehicles requires all personal property must be registered to the current address within 60 days of relocation.
- ☐ Mailed letter from a government agency (TANIF, HUD, ARHA, IRS, etc.) The letter must be addressed to the parent/legal guardian or adult student.
- ☐ Current pay stub (with Alexandria City address and noting Virginia tax withholding).
- ☐ Latest federal/state income tax return noting the Alexandria City address.
- ☐ 2 consecutive bank statements mailed to the Alexandria City address.
- ☐ Current homeowner or renter's insurance policy noting an Alexandria City address.

**OR**

## Category C: Please confer with the school registrar if either of the following apply.

- ☐ Lack of housing, in transition or are experiencing homelessness.
- ☐ Foster Care/DSS: Provide verification that the student is in the custody of the Department of Social Services, in the form of a court order or official documentation from the Department of Social Services.



Student's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_ School Year: \_\_\_\_\_

**STUDENT HEALTH CONDITIONS**

Check all boxes that apply to the student.

**ALLERGIES** ☐ Yes ☐ No**Allergy Type:**☐ Food List food(s): \_\_\_\_\_☐ Medication List medication(s): \_\_\_\_\_☐ Bee stings or insect bites☐ Other: \_\_\_\_\_

Date of last severe reaction: \_\_\_\_\_

Date of last hospital or emergency room visit due to allergies: \_\_\_\_\_

**Currently prescribed medications and treatments for allergies:**☐ Oral antihistamine (Benadryl, etc.)☐ Epinephrine ☐ Has Epinephrine Injector☐ Other: \_\_\_\_\_**FOOD RESTRICTIONS** ☐ Yes ☐ No☐ Due to Gastrointestinal (Digestive) distress List food(s): \_\_\_\_\_☐ Due to religious or other preferences List food(s): \_\_\_\_\_**ASTHMA** ☐ Yes ☐ No**Currently prescribed medications and treatments for asthma:**☐ Daily control (prevention) medication☐ As needed (rescue) medication

Date of last hospital or emergency room visit due to asthma: \_\_\_\_\_

**DIABETES** ☐ Yes ☐ No

Date of last hospital or emergency room visit due to diabetes: \_\_\_\_\_

**Does the student's diabetes require medication and/or blood testing IN SCHOOL?**☐ No☐ Yes List medication(s): \_\_\_\_\_**SEIZURE DISORDER** ☐ Yes ☐ No**Does the student's seizure disorder require medication IN SCHOOL?**☐ No☐ Yes List medication(s): \_\_\_\_\_

Date of last seizure: \_\_\_\_\_

Date of last hospital or emergency room visit due to seizure: \_\_\_\_\_

**OTHER HEALTH CONDITIONS** ☐ Yes ☐ No

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> ADHD                | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Obstructive Sleep Apnea | <input type="checkbox"/> Cancer                               |
| <input type="checkbox"/> Autism              | <input type="checkbox"/> Hemophilia              | <input type="checkbox"/> Nutritional Disorder    | <input type="checkbox"/> Chronic Infection (Hepatitis C, HIV) |
| <input type="checkbox"/> Cerebral Palsy      | <input type="checkbox"/> Sickle Cell Disease     | <input type="checkbox"/> Physical Disability     | <input type="checkbox"/> Congenital/Chromosomal Disorders     |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Cystic Fibrosis         | <input type="checkbox"/> Eczema                  | <input type="checkbox"/> Depression                           |

☐ Other physical or mental health conditions: \_\_\_\_\_
**Does the student's condition require IN SCHOOL USE of the following?**
**Medications:** ☐ No ☐ Yes List medication(s): \_\_\_\_\_

**Special procedures:** ☐ No ☐ Yes List procedure(s): \_\_\_\_\_

**Special equipment:** ☐ No ☐ Yes List equipment: \_\_\_\_\_
**VISION CONDITIONS** ☐ Yes ☐ No

- ☐
- Glasses
- 
- ☐
- Contacts
- 
- ☐
- Non correctable
- 
- ☐
- Other: \_\_\_\_\_

**HEARING CONDITIONS** ☐ Yes ☐ No

- ☐
- Hearing aid(s)
- 
- ☐
- Non correctable
- 
- ☐
- Other: \_\_\_\_\_

**STUDENT HEALTH CARE AND HEALTH COVERAGE**
**Does the student have health insurance?** ☐ No ☐ Yes Name of health insurance company: \_\_\_\_\_

Name of student's primary care doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

**Does the student have dental insurance?** ☐ No ☐ Yes Name of dental insurance company: \_\_\_\_\_

Name of student's dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

**PARENT/GUARDIAN AUTHORIZATION**

**In the case of an emergency, school staff will call 911. Every attempt will be made to contact a parent, legal guardian or emergency contact. Students will be transported to the nearest Emergency Room unless the parent is on the school premises to assume responsibility for the child.**

The parent/guardian is responsible for providing the school with any medication, special food, supplies, or equipment that the student requires during the school day. Check with the school nurse or registrar to obtain correct medication and procedural forms. If an individual school health care plan is indicated, the parent/guardian is responsible for providing the school nurse with necessary medical information, appropriate authorization forms and written consent to exchange information with the child's physician.

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.*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# STUDENT-PARENT SURVEY

Survey Date 10/31/2024

Each Section **MUST** be Completely Filled in Where Applicable

ACPS may receive federal grant funds for enrolling students who are federally connected. If no parent or guardian in your household lives or works on federal property, please complete Section 1 and sign and date at the bottom of the form.

## Section 1: STUDENT INFORMATION

Student Name: Last	First	Middle	Student ID
<hr/>			
Address: Number & Street	City	State	Zip Code
<hr/>			
Name of School	Grade	Birth Date	Home Phone
<hr/>			
If the above property is federal property, please enter the name of the property			
<hr/>			

## Section 2 – EMPLOYMENT INFORMATION: CIVILIANS ONLY working on federal property

Parent/Guardian Name: Last	First	MI	Employer Name	
<hr/>				
Employer Address (Physical Location)	Building Number & Street	City	State	Zip Code
<hr/>				
Federal Property Name ( <i>see back side for list of eligible federal properties</i> )				
<hr/>				
Federal Property Address	Number & Street	City	State	Zip Code
<hr/>				

## Section 3 – PARENT/GUARDIAN EMPLOYMENT INFORMATION: UNIFORMED SERVICES PARENT/GUARDIAN

Enter information in this section if either parent/guardian was on active duty in the Uniformed Services of the United States on the survey date. (If both parents in the household are in the military at the time of the survey date, please fill out a second form).

☐ Student is not military connected – (Do not complete any further in Section 3)

### Branch of Active Service:

- ☐ Air Force    ☐ Army    ☐ Coast Guard    ☐ Marine Corps    ☐ Navy
- ☐ The Commissioned Corps of the National Oceanic and Atmospheric Administration – NOAA
- ☐ The Commissioned Corps of the of the U.S. Public Health Services – USPHS
- ☐ National Guard or Reserves mobilized by Presidential Executive Order 13223 of 9/14/2001 and Title 10 USC (Attach Copy of Activation Orders)
- ☐ National Guard; Reserve
- ☐ Reserve; Student is a dependent of a member of the Reserve Forces (Army, Navy, Air Force, Marine Corps or Coast Guard).

Parent/Guardian Name (Last, First and MI)

Military Rank/Grade

## Section 4 – PARENT/GUARDIAN EMPLOYMENT INFORMATION: FOREIGN MILITARY

Enter information in this section if either parent/guardian was on **active duty** on the survey date. If not, skip this section.

Parent/Guardian Name (Last, First and MI)	Foreign Government Name
<hr/>	
Military Rank/Grade	Branch of Service
<hr/>	

This information is used to support our request for federal funds under the Impact Aid Program (Title VIII of the Elementary and Secondary Act). This information may be provided to the U.S. Department of Education if our application for federal funds is audited. This form must be signed and dated for ACPS to receive its fair share of federal funds.

By signing this form, I am certifying that all typed and written information on this form is accurate and complete as of the survey date.

Signature of Parent/Guardian

Date [mm/dd/yyyy]

## Eligible Federal Properties

- Albert V Bryan Federal Courthouse, 401 Courthouse Sq., Alexandria, VA 22314
- Mt. Weather EOC, 19844 or 19850 Blue Ridge Mountain Rd, Bluemont, VA 20135
- Arlington National Cemetery, Arlington, VA 22211
- MVB Bostetter, Courthouse, 200 S Washington St, Alexandria, VA 22314
- CIA Langley Campus, 1000 Colonial Farm Rd, McLean, VA22101
- Naval Surface Warfare Center, 17320 Dahlgren Rd, Dahlgren, VA 22448
- CIA NRO, 14675 Lee Rd, Chantilly, VA 20151
- NOAA NWS, 43858 or 43872 Weather Service Rd, Sterling, VA 20166
- Dulles International Airport, 1 Saarinen Ci, Sterling, VA 20166
- Pentagon [include bldg location in street address], Arlington, VA 22202
- FAA Air Route Traffic Control Center, 825 E Market St, Leesburg, VA20176
- Ronald Reagan National Airport, 1 Aviation Ci, Arlington, VA 22202
- FAA Potomac TRACON, 3699 Macintosh Dr, Warrenton, VA 20187
- Ronald Reagan National Airport, 2401 Smith Bv, Arlington, VA 22202
- FBI Academy & Laboratory, 2501 Investigation PW, Quantico, VA22135
- Steven F Udvar Hazy Ctr, 14390 Air and Space Museum Pw, Chantilly, VA 20151
- Fort Belvoir 9910 Tracy Loop, Fort Belvoir, VA 22060
- Turner-Fairbank HRC, 6300 Georgetown Pike, McLean, VA 22101
- Fort Belvoir North (NGA), 7500 Geoint Dr, Springfield, VA 22150
- US Army National Guard, 111 S George Mason Dr, Arlington, VA 22204
- Franconia GSA LOC 6808, 6810, 6999, or 7000 Loisdale Rd, Springfield, VA 22150
- US Army Reserve Center, 6901, or 6978 Telegraph Rd, Alexandria, VA 22310
- George P Schulz NFATC, 4000 Arlington Bv, Arlington, VA 22204
- US Attorney's Office (USDOJ), 2100 Jamieson Ave, Alexandria, VA 22314
- George Washington Memorial Parkway, 700 GW Pw, VA 22101
- US Coast Guard Radio Station, 7323 Telegraph Rd, Alexandria, VA 22315
- Henderson Hall, 1555 Southgate Rd, Arlington, VA 22214
- US Geological Survey, 12201 Sunrise Valley Dr, Reston, VA 20192
- Humphreys Engineer Center, 7701 Telegraph Rd, Alexandria, VA 22315
- Warrenton Training Center – Site A, 8094 Shipmadilly Ln, Warrenton, VA 20186
- Hybla Valley Office Bldg, 6801 Telegraph Rd, Alexandria, VA 22306
- Warrenton Training Center – Site B, 7471 Bear Wallow Rd, Warrenton, VA 20186
- Joint Base Myer-Henderson Hall, Fort Myer, VA 22211
- Warrenton Training Center – Site C, 7248 Sumerduck Rd, Remington, VA 22734
- Marine Corps Base Quantico, 3250 Catlin Ave, Quantico, VA 22134
- Warrenton Training Center – Site D, 22129 Confederate Rd, Elkwood, VA 22718
- Mark Center Federal Office Bldg, 1897 N Beauregard St, Alexandria, VA 22350
- Wolf Trap Farm Park, 1551 Trap Rd, Vienna, VA 22182

## **STUDENT CODE OF CONDUCT FORM**

The *Student Code of Conduct* is made available to every family each school year. By signing this and returning this form, parent(s)/guardian(s) shall not be deemed to waive, but do expressly reserve, their rights to protect by the Constitution or laws of the United States and/or the Commonwealth of Virginia, and shall have the right to express disagreement with the school division's policies and or decisions.

The Student Code of Conduct, required by law, contains guidelines and rules for Responsible Computer System Use Policy for Students; Compulsory School Attendance; Standards of Student Conduct; Equity and Excellence Policy; Bullying Reporting Form; and Honor Code. Parents/guardians have a duty to assist ACPS schools in enforcing the standards of student conduct and compulsory school attendance.

Parents/guardians have a responsibility to understand the Code of Conduct, promote proper student conduct, assist the school with the discipline of the student, and meet with school officials if requested to discuss matters related to discipline and school attendance. The law also requires that parents/guardians sign a statement showing that they know their responsibilities.

Signature of a parent/guardian only acknowledges receipt, and does not require families to agree to any of the policies included therein.

Parent/Guardian Signature: \_\_\_\_\_

Student Signature: \_\_\_\_\_

### **Responsible Use for Technology and Social Media**

As a student, I agree to comply with the guidelines on technology and the internet as written in the Student Code of Conduct.

Parent/Guardian Signature: \_\_\_\_\_

Student Signature: \_\_\_\_\_

### **School Bus Regulations**

School bus regulations are provided in the ACPS Family Handbook. I have read and understand the regulations for students riding a school bus and agree to assume full responsibility for the student's conduct on the school bus.

Parent/Guardian Signature: \_\_\_\_\_

I have read and understand the regulations for students riding a school bus and agree, as a passenger, to abide by these regulations.

Student Signature: \_\_\_\_\_

## **Student Directory Information**

(Family Educational Rights and Privacy Act / FERPA)

Directory information includes a student's name, address, school, photograph, awards and honors, etc. (It does not include the student's social security number.) The primary use of directory information is to publish student information in school-affiliated publications. A full list of directory information is available in the ACPS Family Handbook. ACPS may disclose directory information without written consent, unless the parent/guardian indicates below that the student's information may not be released.

\_\_\_\_\_ **Do NOT** release the student's directory information, except as required by state or federal law, from the date this form is signed until September 15, 2025. **I understand this means that information about and photographs featuring the student will be excluded from school publications such as yearbooks, honor roll listings, and printed graduation/sports/theatrical programs.**

### **PTA Directories and School-Related Organizations**

Many school PTAs and school-related organizations produce an annual directory for families. However, according to Virginia law, no school may disclose the address, telephone number, or email address of a student (unless required by law or as described in the ACPS Family Handbook), unless the parent/guardian affirmatively consents in writing.

\_\_\_\_\_ **YES, ACPS may release** the student/family **telephone number** and **email address** to PTAs, booster organizations, and other school-related organizations from the date this form is signed until September 15, 2025.

### **Media Participation**

Throughout the school year, the student's school or ACPS may want to share photographs or videos of the student, pictures of their art or classwork, passages from their writings or quotations from class discussions, or educational presentations. This includes images on the ACPS website, in ACPS videos, in social media, in school publications (including yearbooks and programs), or shared with third parties including but not limited to local or national media (television, online and print publications).

\_\_\_\_\_ **Do NOT** use the student's photograph, image, voice, writings, classwork or artwork in any of the ways described above from the date this form is signed until September 15, 2025.

### **Student Record Information**

(For High School Parents – 11th and 12th Graders ONLY)

Section 9528 of the No Child Left Behind Act of 2001 requires school systems to provide military recruiters and institutions of higher education with secondary students' names, addresses, and telephone listings upon request. However, parents/guardians (or a student if they are 18 or a legally emancipated minor) may request that the student's name, address and telephone listings not be released without prior written consent. ACPS is, by this form, notifying you of your right to request that your child's information not be released.

If you do **NOT** check any of the options below, the student's information will be released when requested by a military recruiter, prospective employer or an institution of higher education for school year 2024-25.

Please check any of these groups if you do NOT want them to receive the student's information:

\_\_\_\_\_ Do NOT release the student's information to Military Recruiters

\_\_\_\_\_ Do NOT release the student's information to Colleges/Other Educational Institutions

\_\_\_\_\_ Do NOT release the student's information to Prospective Employers



## **Student Record Information**

(For High School Parents – 11th and 12th Graders ONLY)

### **Book Contract**

I hereby agree to replace or pay for any or all student issued technology, textbooks or library books that may be retained, destroyed, lost, or misused, as well as pay all damages caused by the extraordinary wear or use, as assessed by the school.

Parent/Guardian Signature: \_\_\_\_\_

### **Family Life Education**

The Alexandria City Public Schools (ACPS) Family Life Education curriculum is designed to provide a comprehensive, sequential K-10 program that includes age-appropriate instruction in family living and community relationships, abstinence education, human sexuality and reproduction, and the value of postponing sexual activity and benefits of adoption as a positive choice in the event of an unwanted pregnancy. To learn more about the family life curriculum please visit the ACPS Family Life Education website: <https://www.acps.k12.va.us/academics/family-life-education>

Additionally, Family Life Education opt-out information can be found on the ACPS Family Life Education website.



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

**Part I – HEALTH INFORMATION FORM**

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

Name of School: \_\_\_\_\_ Current Grade: \_\_\_\_\_

Student's Name: \_\_\_\_\_  
 Last First Middle

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

Student's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Name of Parent or Legal Guardian 1: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work or Cell: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name of Parent or Legal Guardian 2: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work or Cell: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work or Cell: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

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

Box 1. Pre-Existing Conditions					
Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes: Type 1		
Please list <b>Life Threatening Allergies:</b>			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 ( <input type="checkbox"/> Feeding tube , <input type="checkbox"/> Trach , <input type="checkbox"/> Oxygen support, <input type="checkbox"/> Hearing aids, <input type="checkbox"/> Dental appliance, <input type="checkbox"/> Wheelchair, Hospitalizations, etc.):					

Box 2. Medications			
List all prescription, emergency, over-the-counter, and herbal medications your child takes regularly (Home/ School):			
Medication Name	Dosage	Time Administered ( Home/School)	Notes
1.			
2.			
3.			
4.			
Additional Medications (Name, Dose, Time Administered, Notes)			

Check here if you want to discuss confidential information with the school nurse or other school authority. ☐ Yes ☐ No Please provide the following information:

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

*I \_\_\_\_\_ (do) (do not ) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.*

**Signature of Parent or Legal Guardian:** \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Signature of Interpreter:** \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**COMMONWEALTH OF VIRGINIA  
SCHOOL ENTRANCE HEALTH FORM  
Part II - Certification of Immunization**

Check if the student's  
Immunization  
Records are attached  
using a separate form  
signed by HCP

☐

***Section I***

**See Section II for conditional enrollment and exemptions.**

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box. Please contact your local health department for assistance with foreign vaccine records.

<b>Student Name:</b>		<b>Date of Birth :</b> /      /		<b>Sex:</b>	
<b>Race (Optional):</b>		<b>Ethnicity:</b> <b>Hispanic</b> <b>Non-Hispanic</b>			
<b>IMMUNIZATION</b>	<b>RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN</b>				
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) <input type="checkbox"/> 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
<b>Certification of Immunization</b>					
I certify that this child is <b>ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED</b> in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's <i>Regulations for the Immunization of School Children</i> (Reference Section III).					
Signature of Medical Provider or Health Department Official: _____ Date (Mo., Day, Yr.): ____/____/____					

**Section II**  
**Conditional Enrollment and Exemptions**

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date.  
This section must be attached to Part I Health Information (to be filled out and signed by parent).

Student's Name: \_\_\_\_\_ Date of Birth: |\_\_\_\_|\_\_\_\_|\_\_\_\_|  
Parent or Legal Guardian Name: \_\_\_\_\_  
Parent or Legal Guardian Name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
DTP/DTaP/Tdap : [\_\_\_\_]; DT/Td: [\_\_\_\_]; OPV/IPV: [\_\_\_\_]; Hib: [\_\_\_\_]; PCV: [\_\_\_\_]; RV: [\_\_\_\_]; Measles : [\_\_\_\_];

Mumps: [\_\_\_\_]; Rubella : [\_\_\_\_]; VAR: [\_\_\_\_]; Men ACWY: [\_\_\_\_]; Men B: [\_\_\_\_]; Hep A: [\_\_\_\_]; HBV: [\_\_\_\_]

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

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

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

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

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

**Section III Requirements**

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

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

### Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

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

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

<b>Health Assessment</b>	<b>Date of Assessment:</b> ____/____/____ Weight: _____ lbs. Height: _____ ft. ____ in. Body Mass Index (BMI): _____ BP _____ <input type="checkbox"/> Age / gender appropriate history completed <input type="checkbox"/> Anticipatory guidance provided	<b>Physical Examination</b> 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						
<b>Tuberculosis Screening</b> Check the box that applies: <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"><input type="checkbox"/> No risk for TB infection identified</td> <td style="width: 33%;"><input type="checkbox"/> No symptoms compatible with active TB disease</td> <td style="width: 33%;"><input type="checkbox"/> Risk for TB infection or symptoms identified</td> </tr> </table> Test for TB Infection: TST IGRA Date: _____ TST Reading _____ mm TST/IGRA Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive CXR required if positive test for TB infection or TB symptoms. CXR Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal													<input type="checkbox"/> No risk for TB infection identified	<input type="checkbox"/> No symptoms compatible with active TB disease	<input type="checkbox"/> Risk for TB infection or symptoms identified
<input type="checkbox"/> No risk for TB infection identified	<input type="checkbox"/> No symptoms compatible with active TB disease	<input type="checkbox"/> Risk for TB infection or symptoms identified													
<b>EPSDT Screens <u>Required</u> for Head Start – include specific results and date:</b> Blood Lead: _____ Hct/Hgb _____															

<b>Developmental Screen</b>	<b>Assessed for:</b>	<b>Assessment Method:</b>	<i>Within normal</i>	<i>Concern identified:</i>	<i>Referred for Evaluation</i>
	Emotional/Social				
	Problem Solving				
	Language/Communication				
	Fine Motor Skills				
	Gross Motor Skills				
<b>Hearing Screen</b>	<input type="checkbox"/> Screened at 20dB: Indicate Pass (P) or Refer (R) in each box. <input type="checkbox"/> Screened by OAE (Otoacoustic Emissions): <input type="checkbox"/> Pass <input type="checkbox"/> Referred		<input type="checkbox"/> Referred to Audiologist/ENT <input type="checkbox"/> Unable to test – needs rescreen  <input type="checkbox"/> Permanent Hearing Loss Previously identified: <input type="checkbox"/> Left <input type="checkbox"/> Right  <input type="checkbox"/> Hearing aid or another assistive device		
		1000	2000	4000	
	R				
L					

<b>Vision Screen</b>	<input type="checkbox"/> With Corrective Lenses (Check if yes) <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="4" style="text-align: center;">Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail</td> <td style="text-align: center;"><input type="checkbox"/> Not tested</td> </tr> <tr> <td style="text-align: center;">Distance</td> <td style="text-align: center;">Both</td> <td style="text-align: center;">R</td> <td style="text-align: center;">L</td> <td rowspan="3" style="text-align: center;">Test used:</td> </tr> <tr> <td style="text-align: center;">20/</td> <td style="text-align: center;">20/</td> <td style="text-align: center;">20/</td> <td style="text-align: center;">20/</td> </tr> <tr> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> </tr> </table> <input type="checkbox"/> Pass <input type="checkbox"/> Referred to eye doctor <input type="checkbox"/> Unable to test-needs rescreen	Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/> Not tested	Distance	Both	R	L	Test used:	20/	20/	20/	20/					<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td rowspan="4" style="width: 5%; text-align: center; vertical-align: middle;"><b>Dental Screen</b></td> <td style="width: 95%;"> <input type="checkbox"/> Problems Identified: Referred for Treatment  <input type="checkbox"/> No Problem: Referred for prevention  <input type="checkbox"/> No Referral: Already receiving dental care  <input type="checkbox"/> Unable to perform                 </td> </tr> <tr><td></td></tr> <tr><td></td></tr> <tr><td></td></tr> </table>	<b>Dental Screen</b>	<input type="checkbox"/> Problems Identified: Referred for Treatment <input type="checkbox"/> No Problem: Referred for prevention <input type="checkbox"/> No Referral: Already receiving dental care <input type="checkbox"/> Unable to perform			
	Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/> Not tested																				
	Distance	Both	R	L	Test used:																				
	20/	20/	20/	20/																					
<b>Dental Screen</b>	<input type="checkbox"/> Problems Identified: Referred for Treatment <input type="checkbox"/> No Problem: Referred for prevention <input type="checkbox"/> No Referral: Already receiving dental care <input type="checkbox"/> Unable to perform																								

<b>Recommendations to (Pre) School, Child Care, or Early Intervention Personnel</b>	<b>Summary of Findings (check one):</b> <input type="checkbox"/> Well child; no conditions identified of concern to school program activities <input type="checkbox"/> Conditions identified that are important to schooling or physical activity (complete sections below and/or explain here):	
	<b>Allergy:</b> <input type="checkbox"/> food: _____ <input type="checkbox"/> insect: _____ <input type="checkbox"/> medicine: _____ <input type="checkbox"/> other: _____ Type of allergic reaction: <input type="checkbox"/> anaphylaxis <input type="checkbox"/> local reaction    Response required: <input type="checkbox"/> none <input type="checkbox"/> epinephrine auto-injector <input type="checkbox"/> other: _____	
	<b>Individualized Health Care Plan needed</b> (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)	
	<b>Restricted Activity Specify:</b> _____	
	<b>Developmental Evaluation</b> <input type="checkbox"/> Has IEP <input type="checkbox"/> Further evaluation needed for: _____	
	<b>Medication.</b> Child takes medicine for specific health condition(s). <input type="checkbox"/> Medication must be given and/or available at school.	
	<b>Special Diet Specify:</b> _____	
	<b>Special Needs Specify:</b> _____	
	<b>Other Comments:</b> _____	
	<b>Other Comments:</b> _____	

**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: \_\_\_\_\_

