



**Chesapeake Public Schools
Enrollment Packet
Standard School Enrollment Requirements**

STUDENT NAME: _____

- Chesapeake Public Schools Enrollment Information Sheet
- Chesapeake Public Schools Student Enrollment Form
- Chesapeake School Entrance Health Information Form (Grades PK-12)
- Virginia School Health Form MCH 213 Rev/07
(First Time Virginia Students - Grades PK-5)
- Home Language Survey (If Applicable)
- Immunization Record
- Proof of Address
(Water, Gas, or Electric Bill showing usage within the last 30 days)
- Birth Certificate #
(KG students must be 5 years old no later than September 30th)
- Custody or Court Orders (If Applicable)
- Authorization for Release of Information
- Affirmation of School Status
- Emergency School Closing Information
- SOL Requirements for Transfer Students
- Foster Care Information Form (If Applicable)

Bus Pick Up the First Day of School

Chesapeake Public Schools strives to have transportation arranged for all students by the first day of school. Please enroll your child **by August 4th** to prevent possible transportation delays during the first week of school.

Office Use Only

Entry Code: _____
 Records Request: _____
 Homeroom Teacher: _____
 Transportation AM: _____

Report Card/Withdrawal: _____
 Student Schedule Completed: _____
 Transportation Services: _____
 Transportation PM: _____



CHESAPEAKE PUBLIC SCHOOLS ENROLLMENT INFORMATION

Kindergarten Age Requirement – To be eligible to attend kindergarten in the Chesapeake Public Schools, “a person will have reached his fifth birthday on or before September 30 of the school year...” (Source: Virginia School Laws 22.1-1, 1992 Edition)

Chesapeake students are expected to attend the schools zoned for their residences. The Code of Virginia §22.1-3 (A) states, “The public schools in each school division shall be free to each person of school age who resides within the school division.”

§22.1-264.1; Misdemeanor to make false statements as to school division or attendance zone residency; penalty:

Any person who knowingly makes a false statement concerning the residency of a child, as determined by §22.1-3, in a particular school division or school attendance zone, for the purpose of (i) avoiding the tuition charges authorized by §22.1-5 or (ii) enrollment in a school outside the attendance zone in which the student resides, shall be guilty of a Class 4 misdemeanor and shall be liable to the school division for tuition charges.

§ 22.1-3; ONLY the parent or legal guardian may enroll the student.

School divisions shall comply with the requirements of the federal McKinney-Vento Homeless Education Assistance Improvements Act of 2001, as amended (42 U.S.C. § 11431 et seq.), to ensure that homeless children and youths shall receive the educational services comparable to those offered to other public school students.

If the student is a foster child, the foster parent must provide the correct legal documentation placing the child(ren) with them. They must provide current proof of residency at the time of enrollment.

§18.2-11; Punishment for conviction of a misdemeanor; The authorized punishments for conviction of a misdemeanor are: (d) For Class 4 misdemeanors, a fine of not more than \$250.00. Chesapeake Public Schools will inform the Commonwealth’s Attorney of any violation of Virginia Code §22.1-264.

Bus Pick Up the First Day of School

Chesapeake Public Schools strives to have transportation arranged for all students by the first day of school. Please enroll your child by **August 4th** to prevent possible transportation delays during the first week of school.

Chesapeake Public Schools – School Enrollment Form

Please Print Legibly

GREAT BRIDGE PRIMARY



School Entering: _____ Date: _____

Student Name: _____

Last First Middle

Current Grade: _____ Date of Birth: (MM/DD/YY) _____ Birth State: _____ Birth Country: _____ Male Female

1. Was English the first language the student learned to speak? Yes No (If No, please complete the enclosed home language survey)

2. Ethnicity

NO – Not Hispanic or Latino.
Proceed to Question 3.

YES – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish Culture or origin, regardless of race.
Proceed to Question 3.

3. Race (Required – May select more than one)

American Indian or Alaskan Native: A person having origins in any of the original peoples of North and South America, including Central America, who maintains a tribal affiliation or community attachment.

White: A person having origins in any of the original peoples of Europe, North America, or the Middle East.

Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Black or African American: A person having origins in any of the Black racial groups of Africa or Caribbean Islands, including Bahamas, Barbados, Haiti, Jamaica, Tobago, Trinidad, and West Indies.

Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

4. Student's Home Address: _____ Zip: _____

5. Mailing Address (if different) _____ Zip _____

6. Are you lacking fixed, regular, or adequate housing at this time? Yes No (If Yes, please complete a Residency Questionnaire)

7. Student Currently Lives With: Both Parents Mother Father Court Appointed Guardian (provide documentation)
 Foster Parent Social Worker Name (if applicable): _____

8. Has there ever been a court order awarding custody of this student? Yes No (If Yes, provide documentation)

9. Parent/Guardian Contact Information:

Mother/Stepmother/Legal Guardian's Name: _____ Place of Employment: _____
(Circle title that applies)

Home Address: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Currently in Military Service: Yes No

Father/Stepfather/Legal Guardian's Name: _____ Place of Employment: _____
(Circle title that applies)

Home Address: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Currently in Military Service: Yes No

10. Emergency Contact Numbers (Other than Parent/Legal Guardian)

Name: _____ Relationship: _____ Can pick up student Yes No

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____ Can pick up student Yes No

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____ Can pick up student Yes No

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____ Can pick up student Yes No

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____ Can pick up student Yes No

Home Phone: _____ Work Phone: _____ Cell Phone: _____

11. **Parent/Guardian Military Connection:** Please check the box that pertains to your student (check only one).

- Student is **not military connected**
- Active duty:** Student is dependent of member of Active Duty Forces (full time) Army, Navy, Air Force, Marine Corps, or Coast Guard
- National Guard or Reserve:** Student is dependent of member of the National Guard or Reserve Forces
- Civil Service:** Student is dependent of civilian employee of Dept. of Defense
- Contractor:** Student is dependent of person who is employed on Federal property (not member of Armed Forces or civilian employee of Dept. of Defense)

12. **Was the student born in one of the 50 states, District of Columbia or Puerto Rico?** Yes No (If No, answer question 12)

El estudiante nació en uno de los 50 Estados, el distrito de Columbia y Puerto Rico? Si No (Si No, responde la pregunta 12)

13. **Has the student attended school in one of the 50 states, District of Columbia or Puerto Rico?** Yes No

If yes, list date entered US school: _____

Ha asistido el estudiante a una escuela en uno de los 50 Estados, el distrito de Columbia y Puerto Rico? Si No

Si la respuesta es sí, lista fecha entró Estados Unidos escuela: _____

14. **Are you a Migrant Family? (A family who moves from place to place for seasonal work)** *Es usted una Familia Migrante?* Yes/Si No

15. **Last School Attended:** _____ **Grade Completed:** _____
 Name / City / State / Zip

16. **Has child ever attended a Chesapeake Public School?** Yes No

(If Yes, name of Last Chesapeake Public School: _____ Grade Completed: _____)

17. **If child has ever attended a Private School?** Name of school _____

18. **Has child ever attended a Virginia school?** Yes No (If Yes, name of last Virginia School: _____) (City: _____)

19. **Has child ever repeated a grade?** Yes No (If Yes, which grade _____)

20. **Does the student have an IEP?** Yes No (If Yes, specify below)

- LD ID ED Visually Impaired Hearing Impaired AUT Speech and Language Impaired
- Orthopedically Impaired OHI Other: _____

21. **Has the student attended Chesapeake SECEP Program?** Yes No (If Yes, please choose one) RE-ED Autistic EBICS

22. **Does the student have a 504 plan?** Yes No

23. **Physical Conditions:** Allergies Asthma Poor Vision Diabetes Heart Condition
 Seizures Speech Defect Other: _____

24. **Does the student attend before or after school day care?** Yes No (If Yes, please complete the provider information below)

Before School Care Provider: _____ Phone: _____
 (day care name/address)

After School Care Provider: _____ Phone: _____
 (day care name/address)

25. **List Other Children in Family:**

Name	M/F	Age	School Where Enrolled	Name	M/F	Age	School Where Enrolled
1				3			
2				4			

26. List Persons who **LEGALLY MAY NOT** pick up your child from school (parent must provide copy of court order):

Name of Person	Relationship to Student	Name of Person	Relationship to Student
1		3	
2		4	

IMPORTANT LEGAL NOTICE: Your signature certifies that all information on this form is correct. According to the Code of Virginia, section 22.1-254.1, any person making a false statement concerning the residency of a child in a particular school division or school attendance zone, for the purpose of enrollment in a school outside the attendance zone, in which the student resides, shall be guilty of a class 4 misdemeanor.

Signature of Enrolling Parent/Guardian: _____ Date: _____

Relationship to Student: _____ Phone: _____

SCHOOL ENTRANCE HEALTH INFORMATION FORM

Name: _____ Student ID#: _____
 Last First Middle Name

Birthdate: Mo. _____ Day _____ Year _____ Gender: Male _____ Female _____

Person to call in case of an emergency if parent/guardian is not available:

Name: _____ Phone: _____

Please provide information relative to the general health of your child entering school for the first time and return to principal within 15 days.

ACUTE OR CHRONIC ILLNESSES

- _____ Yes _____ No Asthma
- _____ Yes _____ No Cerebral Palsy
- _____ Yes _____ No Cystic Fibrosis
- _____ Yes _____ No Diabetic (Insulin dependent)
- _____ Yes _____ No Epilepsy
- _____ Yes _____ No Frequent colds
- _____ Yes _____ No Frequent sore throat
- _____ Yes _____ No Hyperthyroidism
- _____ Yes _____ No Hypothyroidism
- _____ Yes _____ No Allergies other than those related to food/drugs: if yes, describe _____
- _____ Yes _____ No Cancer: if yes, describe _____
- _____ Yes _____ No Heart disease: if yes, describe _____

ACCIDENTS

Has your child had any of the following? If yes, describe.

- _____ Yes _____ No Burns requiring treatment _____
- _____ Yes _____ No Bumps to head requiring treatment _____
- _____ Yes _____ No Fractures _____
- _____ Yes _____ No Lacerations or cuts requiring stitches or tetanus booster _____
- _____ Yes _____ No Near drowning _____
- _____ Yes _____ No Poisoning _____
- _____ Yes _____ No Serious falls _____

MEDICATIONS

Is your child using any medicines? If yes, describe.

- _____ Yes _____ No Prescription drugs: identify drug and condition requiring drug _____
- _____ Yes _____ No Over-the-counter drugs (nonprescription): identify drug and reason for use _____
- _____ Yes _____ No Drug allergies: identify drug and reaction _____

NUTRITION

Yes No Abdominal pain
 Yes No Underweight or overweight for age
 Yes No Allergies related to foods: identify food and reaction _____
 Yes No Problems with elimination (bowel movement and/or urination _____

OPERATIONS

Yes No Appendectomy
 Yes No Hernia
 Yes No Tonsillectomy
 Yes No Tubes in ear
 Other _____

ORTHOPEDIC CONDITION/DEVICES

Yes No Scoliosis
 Yes No Spina bifida
 Other _____
 Yes No Wheelchair
 Yes No Special shoes
 Yes No Crutches
 Yes No Braces
 Yes No Helmet

HEARING

Yes No Frequent ear aches
 Yes No Running ear
 Yes No Hard of hearing
 Yes No Uses hearing aid

BLOOD DISORDERS

Yes No Anemia
 Yes No Leukemia
 Yes No Hemophilia
 Yes No Sickle Cell Anemia

COMMUNICATION

Yes No Speech understandable
 Yes No Stutters/stammers
 Yes No Lisps

HABITS

Yes No Sleeps/Rests well
 Yes No Exercises daily
 Yes No Eats well
 Yes No Bathes regularly
 Yes No Brushes teeth regularly

DENTAL

Yes No Cavities
 Yes No Cleft lip or palate
 Yes No Gum disease
 Yes No Lost some or all baby teeth
 Yes No Permanent teeth appearing
 Yes No Wears dental braces

VISION

Yes No Wears glasses
 Yes No Rubs eyes frequently
 Yes No Squints
 Yes No Color blind

MENTAL AND EMOTIONAL

Yes No Bullies others
 Yes No Cries often
 Yes No Lethargic (slow/lazy)
 Yes No Short attention span
 Yes No Toilet trained
 Yes No Very sensitive
 Yes No Very shy
 Yes No Generally happy

SKIN AND HAIR

Yes No Visible scars
 Yes No Hives
 Yes No Scabies
 Yes No Body lice
 Yes No Head lice

Were there any prenatal or birth complications which affected the child? _____

Please indicate any other condition(s) your child has that is not covered on form. _____

Signed: _____ Date: _____

(Signature of Parent/Guardian)

CS1,260/R06

**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.

GREAT BRIDGE PRIMARY

Name of School: _____ Current Grade: _____
 Student's Name: _____
 Student's Date of Birth: _____/_____/_____ Last First Middle
 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:

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

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 _____ <input type="checkbox"/> Age / gender appropriate history completed <input type="checkbox"/> Anticipatory guidance provided	Physical Examination 1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment <table style="width:100%; border:none;"> <tr> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> </tr> <tr> <td>HEENT</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Neurological</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Skin</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>Lungs</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Abdomen</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Genital</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>Heart</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Extremities</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Urinary</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> </table>		1	2	3		1	2	3		1	2	3	HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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TB Screening: <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																																																		
Test for TB Infection: TST IGRA Date: _____ TST Reading _____ mm TST/IGRA Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative CXR required if positive test for TB infection or TB symptoms. CXR Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal																																																		
EPSDT Screens Required for Head Start – include specific results and date: Blood Lead: _____ Hct/Hgb _____																																																		

Developmental Screen	<i>Assessed for:</i>	<i>Assessment Method:</i>	<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				

Hearing Screen	<input type="checkbox"/> Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.				<input type="checkbox"/> Referred to Audiologist/ENT <input type="checkbox"/> Unable to test – needs rescreen <input type="checkbox"/> Permanent Hearing Loss Previously identified: ___Left ___Right <input type="checkbox"/> Hearing aid or other assistive device
		1000	2000	4000	
	R				
L					
<input type="checkbox"/> Screened by OAE (Otoacoustic Emissions): <input type="checkbox"/> Pass <input type="checkbox"/> Refer					

Vision Screen	<input type="checkbox"/> With Corrective Lenses (check if yes)				
	Stereopsis	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Not tested	
	Distance	Both	R	L	Test used:
		20/	20/	20/	
<input type="checkbox"/> Pass <input type="checkbox"/> Referred to eye doctor <input type="checkbox"/> Unable to test – needs rescreen					

Dental Screen	<input type="checkbox"/> Problem Identified: Referred for treatment <input type="checkbox"/> No Problem: Referred for prevention <input type="checkbox"/> No Referral: Already receiving dental care
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Recommendations to (Pre)School, Child Care, or Early Intervention Personnel	Summary of Findings (check one): <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): _____
	Allergy <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: _____
	Individualized Health Care Plan needed (e.g., asthma, diabetes, seizure disorder, severe allergy, etc) Restricted Activity Specify: _____
	Developmental Evaluation <input type="checkbox"/> Has IEP <input type="checkbox"/> Further evaluation needed for: _____
	Medication. Child takes medicine for specific health condition(s). <input type="checkbox"/> 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) <input type="checkbox"/> 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: _____



CHESAPEAKE PUBLIC SCHOOLS HOME LANGUAGE SURVEY

Federal regulations require that we screen ALL students in grades K-12 to determine their dominant language. The following questions must be answered:

Date: ___/___/___

Name of Student: *(please print)* _____
LAST
FIRST
MIDDLE

1. Where was the student born? Date of Birth: ___/___/___ Current Age: ___

- United States **or** Other country: _____
- Date of Arrival in the United States: ___/___/___
 - Date Student Entered a U.S. School: ___/___/___
 - Date Student Entered a Virginia: ___/___/___

2. Has the student ever received ESL or ESOL services? Yes No Not sure
 If yes: (Dates ___/___/___ School District/State _____)

	English	Spanish	Tagalog	Vietnamese	Other: <i>(specify)</i> <small>If Chinese, please specify whether Cantonese, Hakka, or Mandarin</small>
3. What language did the student learn to speak first?					
4. What language does the student speak most of the time at home?					
5. What language is most often spoken to the student at home?					
6. What language do the adults speak most often at home?					

Federal regulations require that all language minority children be screened to determine English language proficiency for academic success in school. Screening takes approximately one hour or less.

Your signature below indicates understanding of the federally required screening for your child to determine his/her English language proficiency.

Signature of Parent/Guardian Relationship to Student

Printed Name of Parent/Guardian Telephone Number

-----To Be Completed By Enrolling School-----

The original HLS should be filed in the student's cumulative folder. The Country of Birth and Date of Arrival in the U.S. must be completed. If the answer to question 3 is other than English, or if you cannot communicate with the student, send a copy of this survey immediately to the ESL Tutor in your building after entering the following information:

GREAT BRIDGE PRIMARY

School: _____

Student Identification Number: _____ Grade Placement: _____

Name of School Employee Completing Enrollment: _____



CHESAPEAKE PUBLIC SCHOOLS

ENCUESTA DE IDIOMA MATERNO

Las regulaciones federales requieren que examinemos a **TODOS** los estudiantes en los grados K-12 para determinar su idioma dominante. Las siguientes preguntas deben ser respondidas:

Fecha: ___/___/___

Nombre del Estudiante: _____
(en letra de imprenta, por favor) APELLIDO PRIMER NOMBRE SEGUNDO NOMBRE

1. ¿Dónde nació el estudiante? Fecha de nacimiento : ___/___/___ Edad actual: _____

Estados Unidos Otro país: _____

- Fecha en que llegó a los Estados Unidos: ___/___/___
- Fecha en que el estudiante ingresó a una Escuela en los Estados Unidos: ___/___/___
- Fecha en que el estudiante ingresó a una Escuela en Virginia: ___/___/___

2. ¿Ha recibido el estudiante servicios de ESL o ESOL? Sí No No estoy seguro

En caso afirmativo: (Fechas ___/___/___ Distrito Escolar/Estado: _____)

	Inglés	Español	Tagálog	Vietnamita	Otro: <i>(especificar)</i> <small>Si es Chino, por favor especifique si es Cantonés, Hakka, o Mandarín</small>
3. ¿Cuál es el idioma que aprendió el estudiante a hablar primero ?					
4. ¿Cuál es el idioma que el estudiante habla la mayor parte del tiempo en la casa?					
5. ¿En qué idioma le hablan con más frecuencia al estudiante en la casa?					
6. ¿En qué idioma los adultos hablan con más frecuencia en la casa?					

Las regulaciones federales requieren que todos los niños de minorías lingüísticas sean examinados para determinar el dominio de la lengua Inglesa para el éxito académico escolar. El examen dura aproximadamente una hora o menos.

Su firma abajo indica comprensión de la examinación requerida por el gobierno federal para determinar el dominio del idioma Inglés de su hijo.

Firma del Padre/Tutor

Relación con el Estudiante

Nombre Impreso del Padre/Tutor

Número de Teléfono

-----**Para Ser Completado por la Escuela que Inscribe al Alumno**-----
The original HLS should be filed in the student's cumulative folder. The Country of Birth and Date of Arrival in the U.S. must be completed. If the answer to question 3 is other than English, or if you cannot communicate with the student, send a copy of this survey immediately to the ESL Tutor in your building after entering the following information:

School: **GREAT BRIDGE PRIMARY** _____

Student Identification Number: _____ Grade Placement: _____

Name of School Employee Completing Enrollment: _____



WE PROMOTE EXCELLENCE

CHESAPEAKE PUBLIC SCHOOLS

AUTHORIZATION FOR RELEASE OF INFORMATION

Student's Full Name	Date of Birth	Name of Chesapeake Public School GREAT BRIDGE PRIMARY	Grade
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SEND INFORMATION TO:

RELEASE INFORMATION FROM:

School/Agency GREAT BRIDGE PRIMARY	_____ School/Agency _____
ATTN: CHESAPEAKE PUBLIC SCHOOLS	_____ ATTN: _____
Address: 408 CEDAR ROAD	_____ Address _____
CHESAPEAKE VA 23322	_____ City _____ State _____ Zip _____
City 757-547-1135 FAX 757-547-1820	_____ Telephone # _____ Fax # _____

I hereby authorize the following checked information contained in the record of the above named student to be released for the purpose of _____ :

- | | |
|---|---|
| <input type="checkbox"/> Activity Records | <input type="checkbox"/> OT/PT Reports |
| <input type="checkbox"/> Anecdotal Records | <input type="checkbox"/> Progress/Treatment Reports |
| <input type="checkbox"/> Attendance Records | <input type="checkbox"/> Psychiatric Reports |
| <input type="checkbox"/> Classroom Observation | <input type="checkbox"/> Psychological Reports |
| <input type="checkbox"/> Current IEP/ITP | <input type="checkbox"/> Section 504 Plans |
| <input type="checkbox"/> Discipline | <input type="checkbox"/> Social Security Number |
| <input type="checkbox"/> Educational Reports | <input type="checkbox"/> Sociocultural Reports |
| <input type="checkbox"/> Eligibility Minutes | <input type="checkbox"/> Speech/Language Reports |
| <input type="checkbox"/> Grades | <input type="checkbox"/> Standardized Test Scores |
| <input type="checkbox"/> Health Records | <input type="checkbox"/> Vision/Hearing Reports |
| <input type="checkbox"/> Literacy Passport Test Results | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Medical Reports | |

In order to coordinate educational plans for the above named student, I also authorize the receiving agency _____ to release the following checked information to Chesapeake Public Schools:

- | | |
|---|--|
| <input type="checkbox"/> Anecdotal Records | <input type="checkbox"/> Psychiatric Reports |
| <input type="checkbox"/> Classroom Observation | <input type="checkbox"/> Psychological Reports |
| <input type="checkbox"/> Current IEP/ITP | <input type="checkbox"/> Section 504 Plans |
| <input type="checkbox"/> Educational Reports | <input type="checkbox"/> Sociocultural Reports |
| <input type="checkbox"/> Eligibility Minutes | <input type="checkbox"/> Speech/Language Reports |
| <input type="checkbox"/> Medical Reports | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> OT/PT Reports | |
| <input type="checkbox"/> Progress/Treatment Reports | |

I understand that copies of released records will be made available to me upon request.

Signature of Parent/Guardian or Student 18 years or older Date

CS-1,192/R-06

CHESAPEAKE PUBLIC SCHOOLS AFFIRMATION OF SCHOOL STATUS

Pursuant to Section 22.1-3.2 of the Code of Virginia and Chesapeake Public School Board Policy P 9-25 H, the following is a true and accurate reporting of the school status of:

_____ on this day _____.
(Student Name) (Date)

- IS THIS STUDENT CURRENTLY UNDER EXPULSION OR SUSPENSION FROM A PUBLIC OR PRIVATE SCHOOL IN VIRGINIA OR ANOTHER STATE?

_____ YES _____ NO

- IS THIS STUDENT CURRENTLY UNDER THE THREAT OF EXPULSION OR SUSPENSION FROM A PUBLIC OR PRIVATE SCHOOL IN VIRGINIA OR ANOTHER STATE?

_____ YES _____ NO

If the answer to either question is "YES," indicate the appropriate reason(s):

_____ Weapon(s) related charge _____ Alcohol

_____ Infliction of injury to another person _____ Drugs

_____ Other (specify) _____

- IS THIS STUDENT BEING RECOMMENDED FOR, OR CURRENTLY ATTENDING, AN ALTERNATIVE PLACEMENT AT THIS TIME?

_____ YES _____ NO

- ACCORDING TO THE CODE OF VIRGINIA, CERTAIN CRIMINAL ACTIVITIES MUST BE REPORTED TO SCHOOLS. THEREFORE, HAS THE STUDENT YOU ARE ENROLLING BEEN CHARGED OR FOUND GUILTY OF OR ADJUDICATED DELINQUENT FOR ANY OFFENSE LISTED IN SUBSECTION G OF THE CODE OF VIRGINIA 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?*

_____ YES _____ NO

If "YES," explain: _____

**If you have specific questions, please contact the Office of Pupil Discipline: 547-1318.*

I hereby swear and affirm that the above responses are true and accurate under penalty of Section 22.1-3.2 of the code of Virginia. A materially false statement(s) or affirmation shall, upon conviction, be classified as a Class 3 misdemeanor, which is punishable by a fine of not more than \$500.00.

Signature (Must be the parent/guardian)

(Date)

EMERGENCY SCHOOL CLOSING FORM

STUDENT NAME _____ TEACHER _____

In the Event of an Early School Dismissal, my child should:

_____ Ride Bus # _____ Home (*If AM Kindergarten, this would be their morning pick-up bus*)

_____ Be picked up by the daycare van

_____ Be picked up by _____

*Name of person(s)

*The parent will need to call that person if it is someone other than parent.

_____ Ride Bus # _____ to my child's sitter/daycare:

Daycare/Sitter Name: _____

Daycare/Sitter Address: _____

Daycare/Sitter Phone: _____

Early School Closing typically becomes necessary when weather suddenly changes. The Parent Alert System will call you with a pre-recorded message advising you of the Early Closing before students are released. I understand it is the parent(s) responsibility to make plans for their child's after school care whenever an emergency dismissal is required.

Parent Signature _____ Date _____



SOUTHSIDE LIONS CLUB

1700 Taft Road
Chesapeake, Va. 23322

Consent Form for Screening for Vision Problems

Your child will be offered a free vision screening as part of the school nurse's vision and hearing evaluation. The screening will be performed by the Southside Lions Club and consists of either or both of the following – instant photographs of your child's eyes to determine the presence of eye disorders or the reading of an eye chart and testing with a stereoscopic ("3D") picture. **No physical contact is made with your child and eye drops are not necessary.**

I, the undersigned, hereby give permission for my child, _____ to participate in the screening event. I understand the following:

1. There is **no charge** to participate in the vision screening process.
2. I will be contacted with the results.
3. The information obtained from this vision screening is to be considered a preliminary procedure only and does not constitute a diagnosis of vision problems. It should be part of a comprehensive eye care program that includes periodic eye exams.
4. I understand that I am responsible for arranging for a full eye exam with an eye care professional if my child is referred as a result of the vision screening test.
5. I understand that the organization conducting the screening will not be held accountable for any errors of commission, omission or misdiagnosis.

Signature of Parent or Guardian	Printed Name	Date
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Child's Name	Home Phone
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Date of Birth	Age	Address
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Male Female