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:__________________ Report Card/Withdrawal:__________________

Records Request:______________ Student Schedule Completed:______________

Homeroom Teacher:____________ Transportation Services:__________________

Transportation AM:____________ Transportation PM:______________________

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Revised 3/24/2015

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.

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§ 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

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Rev 3/24/2015

Chesapeake Public Schools – School Enrollment Form

Please Print Legibly

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	**3. Race (Required – May select more than one)**
☐ **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.	☐ **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 13)
El estudiante nacio en uno de los 50 Estados, el distrito de Columbia y Puerto Rico? ☐ Si ☐ No (*Si* ***No,*** *responde la pregunta 13*)

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: ______________________________

WE PROMOTE EXCELLENCE

CHESAPEAKE PUBLIC SCHOOLS

AUTHORIZATION FOR RELEASE OF INFORMATION

Student's Full Name	Date of Birth	Name of Chesapeake Public School	Grade

SEND INFORMATION TO:	RELEASE INFORMATION FROM:
School/Agency ______	School/Agency ______
ATTN: ______	ATTN: ______
Address ______	Address ______
City ______ State ____ Zip ______	City ______ State ____ Zip ______
Telephone # ______ Fax # ______	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 ____:

- ❒ Activity Records
- ❒ Anecdotal Records
- ❒ Attendance Records
- ❒ Classroom Observation
- ❒ Current IEP/ITP
- ❒ Discipline
- ❒ Educational Reports
- ❒ Eligibility Minutes
- ❒ Grades
- ❒ Health Records
- ❒ Literacy Passport Test Results
- ❒ Medical Reports
- ❒ OT/PT Reports
- ❒ Progress/Treatment Reports
- ❒ Psychiatric Reports
- ❒ Psychological Reports
- ❒ Section 504 Plans
- ❒ Social Security Number
- ❒ Sociocultural Reports
- ❒ Speech/Language Reports
- ❒ Standardized Test Scores
- ❒ Vision/Hearing Reports
- ❒ Other ______________________

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:

- ❒ Anecdotal Records
- ❒ Classroom Observation
- ❒ Current IEP/ITP
- ❒ Educational Reports
- ❒ Eligibility Minutes
- ❒ Medical Reports
- ❒ OT/PT Reports
- ❒ Progress/Treatment Reports
- ❒ Psychiatric Reports
- ❒ Psychological Reports
- ❒ Section 504 Plans
- ❒ Sociocultural Reports
- ❒ Speech/Language Reports
- ❒ Other ______________________

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

THE CHESAPEAKE PUBLIC SCHOOL SYSTEM IS AN EQUAL EDUCATIONAL OPPORTUNITY SCHOOL SYSTEM. THE SCHOOL BOARD OF THE CITY OF CHESAPEAKE ALSO ADHERES TO THE PRINCIPLES OF EQUAL OPPORTUNITY IN EMPLOYMENT AND, THEREFORE, PROHIBITS DISCRIMINATION IN TERMS AND CONDITIONS OF EMPLOYMENT ON THE BASIS OF RACE, SEX, NATIONAL ORIGIN, COLOR, RELIGION, AGE, OR DISABILITY.

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)

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: *(specify)* *If Chinese, please specify whether Cantonese, Hakka, or Mandarin*
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:*

School: ____

Student Identification Number: ______________________ ***Grade Placement:*** __________

Name of School Employee Completing Enrollment: ______________________________

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

COMMUNICATION

_________Yes _________No Speech understandable
_________Yes _________No Stutters/stammers
_________Yes _________No Lisps

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

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

BLOOD DISORDERS

_________Yes _________No Anemia
_________Yes _________No Leukemia
_________Yes _________No Hemophilia
_________Yes _________No Sickle Cell Anemia

HABITS

_________Yes _________No Sleeps/Rests well
_________Yes _________No Exercises daily
_________Yes _________No Eats well
_________Yes _________No Bathes regularly
_________Yes _________No Brushes teeth regularly

VISION

_________Yes _________No Wears glasses
_________Yes _________No Rubs eyes frequently
_________Yes _________No Squints
_________Yes _________No Color blind

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)

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

Part I – HEALTH INFORMATION FORM

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

Name of School: ______________________ Current Grade: __________

Student's Name: ______________________ Last ______ First ______ Middle

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

Student's Address: ______________________ City: __________ State: ________ Zip: ________

Name of Parent or Legal Guardian 1: ______________________ Phone: ____-____-_____ Work or Cell: ____-____-____

Name of Parent or Legal Guardian 2: ______________________ Phone: ____-____-_____ Work or Cell: ____-____-____

Emergency Contact: ______________________ Phone: ____-____-_____ Work or Cell: ____-____-____

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

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

____

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

____

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

Please provide the following information:

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

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

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

Signature of Parent or Legal Guardian: ______________________ Date: _____/_____/ ______

Signature of person completing this form: ______________________ Date:_____/_____/______

Signature of Interpreter: ______________________ Date: _____/_____/______

MCH 213G reviewed 03/2014

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

Part II - <u>Certification of Immunization</u>

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: ______________________ (Last) ______________________ (First) ______________________ (Middle) Date of Birth: |____|____|____| (*Mo. Day Yr.*)

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

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

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

Student's Name:________________________________ Date of Birth: |___|___|___|

Section II
Conditional Enrollment and Exemptions

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

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

____

____

____.

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

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

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

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

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

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

Section III
Requirements

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

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

Part III – COMPREHENSIVE PHYSICAL EXAMINATION REPORT

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

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

Health Assessment

Date of Assessment: ___/___/_____

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

Body Mass Index (BMI): _________ BP_________

☐ Age / gender appropriate history completed

☐ Anticipatory guidance provided

Physical Examination

1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment

	1	2	3		1	2	3		1	2	3
HEENT	☐	☐	☐	Neurological	☐	☐	☐	Skin	☐	☐	☐
Lungs	☐	☐	☐	Abdomen	☐	☐	☐	Genital	☐	☐	☐
Heart	☐	☐	☐	Extremities	☐	☐	☐	Urinary	☐	☐	☐

TB Screening: ☐ No risk for TB infection identified ☐ No symptoms compatible with active TB disease
☐ Risk for TB infection or symptoms identified
Test for TB Infection: TST IGRA Date:_______ TST Reading _____mm TST/IGRA Result: ☐ Positive ☐ Negative
CXR required if positive test for TB infection or TB symptoms. CXR Date: _________ ☐ Normal ☐ Abnormal

EPSDT Screens Required for Head Start – include specific results and date:
Blood Lead:_______________ Hct/Hgb _______________

Developmental Screen

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

Hearing Screen

☐ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.

	1000	2000	4000
R			
L			

☐ Screened by OAE (Otoacoustic Emissions): ☐ Pass ☐ Refer

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

☐ Permanent Hearing Loss Previously identified: ___Left ___Right

☐ Hearing aid or other assistive device

Vision Screen

☐ With Corrective Lenses (check if yes)

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

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

Dental Screen

☐ Problem Identified: Referred for treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

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

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

___ **Allergy** ☐ food: __________ ☐ insect: __________ ☐ medicine: __________ ☐ other: __________
Type of allergic reaction: ☐ anaphylaxis ☐ local reaction Response required: ☐ none ☐ epinephrine auto-injector ☐ other: ________

___ **Individualized Health Care Plan needed** (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)

___ **Restricted Activity** Specify: ____________________

___ **Developmental Evaluation** ☐ Has IEP ☐ Further evaluation needed for: ____________________

___ **Medication.** Child takes medicine for specific health condition(s). ☐ Medication must be given and/or available at school.

___ **Special Diet** Specify: ____________________

___ **Special Needs** Specify: ____________________

Other Comments: ____________________

Health Care Professional's Certification (Write legibly or stamp) ☐ **By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).**

Name: ____________________ **Signature:** ____________________ Date: ___/___/_____

Practice/Clinic Name: ____________________ **Address:** ____________________

Phone: ____-____-________ **Fax:** ____-____-________ **Email:** ____________________