



Chesapeake Public Schools Enrollment Packet

Standard School Enrollment Requirements

- 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)
- Immunization Record
- Proof of Address
- Birth Certificate
- Custody or Applicable Court Orders
- Home Language Survey
- Authorization for Release of Information
- Affirmation of School Status
- Emergency School Closing Information
- SOL Requirements for Transfer Students



CHESAPEAKE PUBLIC SCHOOLS ENROLLMENT INFORMATION

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 particular school division or school attendance zone, for the purpose of (i) avoiding the tuition charges authorized by §221-5 or (ii) enrollment in a school outside the attendance zone in which the student resides, shall be guilty of a Class 4 misdemeanor.

HB 1222; Tuition liability for false statements of residency within a school division; penalty: Provides that any person who knowingly makes a false statement concerning the residency of a child for the purpose of avoiding tuition charges shall be liable to the school division in which the child was enrolled as a result of such false statements for tuition charges for the time the student was enrolled in the school division.

§ 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.

Chesapeake Public Schools – Student Enrollment Form

Please Print Legibly

For Office Use Only

Enrollment Date: _____ Records Requested: _____ Affirmation of School Status: _____
Entry Code: _____ Custodian Verification: _____ Transportation AM: _____
Birth Certification #: _____ Report Card/Withdrawal: _____ Transportation PM: _____
Address Verification: _____ Student Schedule Completed: _____ Homeroom Teacher: _____
Immunization: _____ Physical Exam (K-6): _____ Transportation Services Required: _____
Home Language Survey Completed: _____

School Information:

School Entering:

Last School Attended: _____ Grade Completed: _____
Name / City / State / Zip
Has child ever attended a Virginia school? Yes No (If **Yes**, name of last Virginia School: _____)
(City: _____)
Has child ever repeated a grade? Yes No (If **Yes**, which grade _____)
Has child ever attended a Chesapeake Public Schools? Yes No
(If **Yes**, name of Last Chesapeake Public School: _____ Grade Completed: _____)

Student Information:

Name: _____
Last First Middle
Grade Level Entering: _____ Date of Birth: _____ Birth State: _____ Male Female
(Month / Day / Year)
Race: Unspecified American Indian/Alaskan Native Asian African American (not of Hispanic origin)
 Hispanic White (not of Hispanic origin) Native Hawaiian or Other Pacific Islander
Currently living with: Both Parents Mother Father
 Court Appointed Guardian (provide documentation) Foster Parent: _____
 Foster Family Placement Social Worker Name (if applicable): _____
Student's Home Address: _____ Zip: _____

Has there ever been a court order awarding custody for this child? Yes No (If **Yes**, provide documentation.)

Services:

Does the student have an IEP? Yes No (If **Yes**, specify below)
 LD EMR ED Visually Impaired Hearing Impaired TMR Speech and Language Impaired
 Orthopedically Impaired OHI Other: _____
Has the student attended Chesapeake SECEP Program? Yes No (If **Yes**, please choose one) RE-ED Autistic EBICS
Does the student have a 504 plan? Yes No
Physical Condition: Allergies Asthma Poor Vision Diabetes Heart Condition
 Seizures Speech Defect Other: _____
Was English the first language the student learned to speak? Yes No (If **No**, please complete the enclosed home language survey.)

Please complete the other side

Parent/Guardian Contact Information:

Currently in Military Service Yes No

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

Home Address: _____ Zip: _____

Currently in Military Service Yes No

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

Home Address: _____ Zip: _____

Other Emergency Contact Name: _____ Relationship to Student: _____

Home Address: _____ Zip: _____

Contact Numbers: Example: Phone #1: (757) 547-0153 Description: Mom at Home - Numbers 1-3 will be used for our Parent Alert System.

Phone #1 () _____ Description: _____ Phone #2 () _____ Description: _____

Phone #3 () _____ Description: _____ Phone #4 () _____ Description: _____

Phone #5 () _____ Description: _____ Phone #6 () _____ Description: _____

E-mail #1 _____ E-mail #2 _____

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: _____
(Local day care name/address)

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

List Other Children in Family:

Name	Gender	Age	School Where Enrolled

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

List Persons who **MAY** pick up your child from school: **NOTE – Prior notification to school required**

Name of Person	Relationship to Student

Signature of Parent/Guardian completing form: _____ Date: _____

Relationship to Student: _____ Phone: _____

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.

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.

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 Mother or Legal Guardian: _____ Phone: _____ - _____ - _____ Work or Cell: _____ - _____ - _____
 Name of Father or Legal Guardian: _____ 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 or spinal injury		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Hospitalizations		
Developmental problems			Lead poisoning		
Bladder problem			Muscle problems		
Bleeding problem			Seizures		
Bowel problem			Sickle Cell Disease (not trait)		
Cerebral Palsy			Speech problems		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example, feeding tube, oxygen support, hearing aid, 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: _____/_____/_____

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 TB Risk Assessment: <input type="checkbox"/> No Risk <input type="checkbox"/> Positive/Referred Mantoux results: _____ mm	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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EPSDT Screens <u>Required</u> 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	<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"/> epi pen <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):		
Name : _____	Signature: _____	Date: ____/____/____
Practice/Clinic Name: _____	Address: _____	
Phone: _____ - _____ - _____	Fax: _____ - _____ - _____	Email: _____



HOME LANGUAGE SURVEY

Date: _____ Name of Student: _____
(Please Print)

Age: _____ Date of Birth: _____ Country of Birth: _____

Date of Arrival in the United States: _____

Date Your Child First Entered a U.S. School: _____ / _____ / _____
Month Day Year

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

1) What language did the child learn to speak first? _____

- If Chinese, please circle one: Hakka Mandarin Cantonese/Yue

2) What language does the child speak most of the time at home? _____

3) What language do the adults speak most often at home? _____

4) Please indicate the status of the student.

U.S. Citizen Yes No

Refugee Yes No

Migrant Yes No

Immigrant Yes No

Signature of Person Completing this Form

Relationship to Student

-----**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 Questions 1 is other than English, or if you cannot communicate with the student, send a copy of this survey immediately to the LEP Supervisor after entering the following information:*

School _____

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	Grade

SEND INFORMATION TO:

School/Agency _____

ATTN: _____

Address _____

City _____ State ____ Zip _____

Telephone # _____ Fax # _____

RELEASE INFORMATION FROM:

School/Agency _____

ATTN: _____

Address _____

City _____ State ____ Zip _____

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:

(Student Name)

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

_____ YES _____ NO

- IS THIS STUDENT CURRENTLY UNDER THE THREAT OF EXPULSION 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

_____ Willful infliction of injury to another person _____ Drugs

_____ Other (specify) _____

- HAS THIS STUDENT BEEN 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: _____

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

Student Name _____ Teacher _____

In the Event of an Early School Dismissal, My Child Should:

_____ Ride Bus# _____ home (*If A.M. Kindergarten, this would be their morning pick up bus*)

_____ Be picked up by the day care van

_____ Walk home

_____ Be picked up by _____
(* Name of Person)

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

_____ Ride Bus # _____ to my neighbor/sitter's home until I arrive.

Neighbor's Name _____

Neighbor's Address _____

Neighbor's Phone # _____

_____ Other (Please explain) _____

Early school closing typically becomes necessary when weather suddenly changes. This plan is important because we will be unable to call the parents of each of our students. I understand that it is the parent(s) responsibility to make plans for their child's after school care whenever an emergency dismissal is required.

Signature _____ Date _____

**SOL REQUIREMENTS FOR
TRANSFER STUDENTS FROM
NON-VIRGINIA PUBLIC SCHOOLS**

**Students entering during the 9th grade or the beginning of
10th grade must satisfy the same verified credit
requirements as students who enrolled at the beginning of
9th grade.**

Students Entering	SOL Requirements Advanced Diploma	SOL Requirements Standard Diploma
During the 10 th grade, or the beginning of 11 th grade	<p>6 verified units of credit:</p> <ul style="list-style-type: none"> 2 English 1 Mathematics 1 History 1 Science 1 of the student's choosing 	<p>4 verified units of credit:</p> <ul style="list-style-type: none"> 1 English 1 History 1 Mathematics 1 Science
During the 11 th grade, or the beginning of the 12 th grade	<p>4 verified units of credit:</p> <ul style="list-style-type: none"> 1 English 3 of the student's choosing 	<p>2 verified units of credit:</p> <ul style="list-style-type: none"> 1 English 1 of the student's choosing
<p>Seniors transferring after 20 instructional hours per course shall be given every opportunity to earn a Standard, Advanced, or Modified Standard Diploma. If this is not possible, arrangements should be made for the student's previous school to award the diploma.</p>		