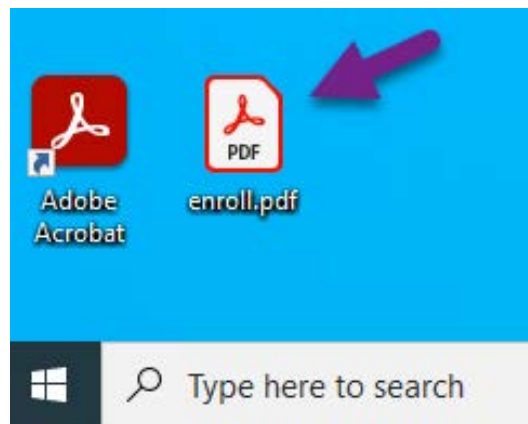


For students enrolling or re-enrolling in Fairfax County Public Schools

This form bundle allows you to enter data once and to have it appear in multiple locations. If you have more than one student, you can use the RESET button to clear out ALL student related information while keeping all parent data. The RESET button operates on ALL pages at once.

To make sure you are printing only the pages you need, we recommend you review each page to make sure it is complete and accurate and then print that page by choosing the print current page option within Adobe.

If filling out the bundle digitally, we recommend using Adobe Acrobat Reader. This is to ensure form fields and buttons work as intended. After installing Adobe Reader, you can change your browser settings to "Download PDF's" to automatically save the bundle onto your device. You may then locate the saved PDF and open in Reader.





Student Registration Form Part A

FCPS Student ID

To Be Completed by Parent or Guardian

Student Legal Name (as it appears on the birth certificate)			Student Previous Name (if any)		
Last	First	Middle	Last	First	Middle
Student Nickname	Date of Birth (mm/dd/yyyy)	Student Home Telephone (ten digits) <input type="checkbox"/> unlisted	Country of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non Binary (as it appears on the birth certificate)	Grade Level

Ethnic Group and Race Categories The federal government **requires** that **both** these questions be answered and provides only the following categories for ethnic group and race. If both questions are not answered, school personnel are **required** to make selections for both.

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

No, not Hispanic or Latino

Yes, Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

2. What is the student's race? (*select all that apply*)

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

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

Black or African American (A person having origins in any of the Black racial groups of Africa.)

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

White (A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.)

Other Children in Family	
Name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____

Residence Address of Student and Enrolling Parent			Dwelling Location (select only one)		
Street	Apt No.	City	State	Zip Code/Suffix	
				<input type="checkbox"/> 5 City of Fairfax	<input type="checkbox"/> 9 Fairfax County
				<input type="checkbox"/> 4 Fort Belvoir	<input type="checkbox"/> 6 Other (not Fairfax County)

Enrolling Parent	Relationship	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Foster Parent	<input type="checkbox"/> Self	<input type="checkbox"/> Caretaker	
Last	First	Middle					This box is only checked by the Department of Special Services Staff.	
E-mail _____								
Contact Numbers ten digits		<input type="checkbox"/> Unlisted	Home _____	Work _____	Cell _____			

Other Parent	Resides With	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relationship	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Foster Parent	<input type="checkbox"/> Stepmother	<input type="checkbox"/> Stepfather
Last	First	Middle								
Address (if different from above) _____										
E-mail _____										
Contact Numbers ten digits		<input type="checkbox"/> Unlisted	Home _____	Work _____	Cell _____					

Other Parent	Resides With	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relationship	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Stepmother	<input type="checkbox"/> Stepfather
Last	First	Middle							
Address (if different from above) _____									
E-mail _____									
Contact Numbers ten digits		<input type="checkbox"/> Unlisted	Home _____	Work _____	Cell _____				

Information from the Fairfax County Public Schools student scholastic record is released on the condition that the recipient agrees not to permit any other party to have access to such information without the written consent of the parent or guardian or of the eligible student.

Title IX Contact Information:	Title IX Coordinator, FCPS titleixcoordinator@fcps.edu https://www.fcps.edu/title-ix	Phone: 571-423-3070 8115 Gatehouse Road Falls Church, VA 22042
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Student Registration Form

Part B

Last

First

Middle

FCPS Student ID

Student Legal Name _____

Number of Full Academic Years Completed in the U.S. in grades K-12 <input type="checkbox"/> 0 <input type="checkbox"/> 2 <input type="checkbox"/> 4 or more <input type="checkbox"/> 1 <input type="checkbox"/> 3	When did your child begin school in the US? Includes public, private, or home school in grades K-12? _____ / _____ (month / year)	Has your child attended a public school in Virginia in grades K-12? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many years? _____	Ever Received a Service from FCPS Before? <input type="checkbox"/> Yes <input type="checkbox"/> No Previous ID _____
---	---	--	--

Ever Attended FCPS Before? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Name of Last School Attended in FCPS _____ Last Year Attended _____	Home Language 1. What is the primary language used in the home, regardless of the language spoken by the student? _____ 2. What is the language most often spoken by the student? _____ 3. What is the language that the student first acquired? _____	Correspondence Language 1. In what language do you wish to receive written communication? _____ 2. In what language do you wish to receive oral communication? _____
Last School Attended NOT in FCPS School Name _____ Street _____ City _____ State _____ Zip Code _____ School Phone (ten digits) _____ School Fax (ten digits) _____		

I affirm that the above registered student **has not been** expelled from school attendance at any private or public school in Virginia or another state for an offense in violation of School Board policies relating to weapons, alcohol, or drugs, or for the willful infliction of injury to another person.

I affirm that the above registered student **has been** expelled from school attendance at a private or public school in Virginia or another state for an offense in violation of School Board policies relating to weapons, alcohol, or drugs, or for the willful infliction of injury to another person.

I affirm that the above registered student is not a party in an ongoing Title IX Investigation.

I affirm that the above registered student has not been found responsible in a Title IX Investigation.

I am aware that making a false statement herein constitutes a class 4 misdemeanor. I am aware that Fairfax County Public Schools (FCPS) staff may verify residency documentation to confirm Fairfax County residency. I am aware that if I move from Fairfax County that the above registered student may no longer be eligible to attend FCPS. I certify that all the information on this student registration form is true and correct to the best of my knowledge and belief.

Parent or Guardian Signature _____ Date _____ Print Name _____

To Be Completed by FCPS Staff (with input from parent or guardian)

Proof of Date of Birth Birth Certificate Number _____		Date of Entry (current) _____ E _____ _____ R _____		Original FCPS Entry Date	Original 9th Grade Entry Date	Student Assignment Placement Code _____ Base School _____	
Affidavit with Supporting Documentation Code _____		Proof of Address Received Document Type(s) _____			Homeless <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuition Code	Contact Restriction <input type="checkbox"/> Yes <input type="checkbox"/> No
Transportation <input type="checkbox"/> Authorized to Ride Bus <input type="checkbox"/> Not Authorized to Ride Bus		Special Education Program Code	AAP Status [1]R [2]S	Counselor	Homeroom	Teacher	

Current Enrolling FCPS School _____

FCPS Staff Signature _____ Date _____ Print Name _____

Information from the Fairfax County Public Schools student scholastic record is released on the condition that the recipient agrees not to permit any other party to have access to such information without the written consent of the parent or guardian or of the eligible student.

HEALTH INFORMATION

Complete this form every school year to inform us about your student's existing and new health conditions that affect your student's school day

This form is necessary to inform the Public Health Nurse (PHN) of your child's health status and to plan for health needs that may impact his/her school day. Information is only shared with required school staff, as needed. Information provided on this form is protected by the Family Educational Rights and Privacy Act (FERPA) as part of the student's education record and is securely stored in the health room. De-identified, aggregate health data is also used by Fairfax County Public Schools (FCPS) and the Fairfax County Health Department (FCHD) to complete required public health reporting to the Virginia Department of Education and to monitor health needs in the school community. For any changes to your student's health condition during the school year or questions regarding this form, please contact the PHN through the health room at your child's school.

Section A: Demographics:

Student Name: Last		First	Middle	Date of Birth
School Year	School Name	Grade	Teacher/Counselor	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary
Parent/Legal Guardian Name		Home Phone Number	Cell Phone Number	Work Phone Number
Parent/Legal Guardian Name		Home Phone Number	Cell Phone Number	Work Phone Number

Section B: Severe or Life-Threatening Health Conditions:

Condition	Check if Yes	Comment
Severe Allergies/Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/> Foods: _____ <input type="checkbox"/> Insect Sting: _____ <input type="checkbox"/> Latex Epinephrine prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No Epinephrine injection previously given? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of injection: _____
Asthma	<input type="checkbox"/>	Triggers: <input type="checkbox"/> Exercise <input type="checkbox"/> Environmental <input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Other: _____ Inhaler prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No Nebulizer Treatment prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of Emergency Room (ER) Visits in the last calendar year: _____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 Diagnosis Date: _____ Name of emergency medication: _____ Glucose Monitoring: <input type="checkbox"/> Glucometer <input type="checkbox"/> CGM Insulin Administration: <input type="checkbox"/> Syringe <input type="checkbox"/> Pen <input type="checkbox"/> Pump
Seizures	<input type="checkbox"/>	Type of Seizure: _____ Date of last seizure: _____ Emergency Medication Needed at school? <input type="checkbox"/> Yes <input type="checkbox"/> No VNS implanted? <input type="checkbox"/> Yes <input type="checkbox"/> No

Section C: Current Physical Health Conditions:

Condition	Check if Yes	Comment (Please provide details)
Height/Weight		Height: ___ ft. ___ in. Weight: _____ lbs.
Allergies (non-life threatening)	<input type="checkbox"/>	
Blood Disorder	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	Currently Immunocompromised <input type="checkbox"/> Yes <input type="checkbox"/> No
Cystic Fibrosis	<input type="checkbox"/>	
Dental/Oral Health Condition	<input type="checkbox"/>	
Ear, Nose & Throat Conditions	<input type="checkbox"/>	Please specify:
Endocrine Disorder (other than Diabetes)	<input type="checkbox"/>	
Food Intolerance	<input type="checkbox"/>	Foods: _____ Gastrointestinal/Digestive Distress <input type="checkbox"/> Yes <input type="checkbox"/> No
Food/Dietary Preference	<input type="checkbox"/>	
Gastrointestinal/Stomach/Bowel	<input type="checkbox"/>	
Hearing Conditions	<input type="checkbox"/>	
Heart/Cardiovascular	<input type="checkbox"/>	
Kidney/Urinary Tract Disorders	<input type="checkbox"/>	
Headache/Migraines	<input type="checkbox"/>	
Lung Disease (other than Asthma)	<input type="checkbox"/>	
Mobility Impairment	<input type="checkbox"/>	

HEALTH INFORMATION

Complete this form every school year to inform us about your student's existing and new health conditions that affect your student's school day

Last Name _____	First Name _____	Date of Birth _____
Section D: Current Health Conditions, Continued:		
Condition	Check if Yes	Comment (Please provide details)
Muscle/Bone/Joint/Arthritis	<input type="checkbox"/>	Please specify: _____
Neurological (other than seizures)	<input type="checkbox"/>	<input type="checkbox"/> Brain Injury/Concussion/Date Diagnosed: _____ <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Other: _____
Skin Condition	<input type="checkbox"/>	<input type="checkbox"/> Eczema <input type="checkbox"/> Other: _____
Vision Conditions	<input type="checkbox"/>	<input type="checkbox"/> Contacts/Glasses <input type="checkbox"/> Non-Correctable <input type="checkbox"/> Other: _____
Other Health Conditions	<input type="checkbox"/>	<input type="checkbox"/> Autism <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Other: _____
Emotional/Mental Health Conditions:		
ADD/ADHD	<input type="checkbox"/>	Provider Diagnosed <input type="checkbox"/> Yes <input type="checkbox"/> No Under Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety	<input type="checkbox"/>	Provider Diagnosed <input type="checkbox"/> Yes <input type="checkbox"/> No Under Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/>	Provider Diagnosed <input type="checkbox"/> Yes <input type="checkbox"/> No Under Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Eating Disorder	<input type="checkbox"/>	Provider Diagnosed <input type="checkbox"/> Yes <input type="checkbox"/> No Under Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Other: _____	<input type="checkbox"/>	Provider Diagnosed <input type="checkbox"/> Yes <input type="checkbox"/> No Under Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Section E: Health Procedures:		
<p>The Fairfax County Health Department provides referral information to community medical resources providing free physical examinations. Visit https://www.fairfaxcounty.gov/health/clinics.</p> <p>If your child has a health condition, does your child require any health procedures or need any special equipment during the school days? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered Yes, please describe: _____</p>		
Section F: List all medications and dosages your child receives on a regular basis and indicate which ones to be taken at school:		
_____ _____ _____ _____		
Parent or guardian is responsible for providing the school with any medication, special food, equipment that the student may require during the day. Medication, Procedure Authorization, and Physical Education (PE) forms may be found at https://www.fcps.edu/registration/forms or obtained in the school Health Room.		
Parental Consent: I agree to allow my child's healthcare provider(s) to discuss information contained in this form with FCPS staff and School Public Health Nurse. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Healthcare Provider Name _____	Healthcare Provider Phone Number _____	
Parent/Guardian Name (Print or Type) _____	Parent/Guardian Signature _____	Date _____
Public Health Nurse Use Only Below This Line		
<input type="checkbox"/> HIF Reviewed <input type="checkbox"/> Follow Protocol (SH Care Emerg.-Temp. Care Guidelines) <input type="checkbox"/> Health Condition List		
<input type="checkbox"/> Mental Health Condition List <input type="checkbox"/> Action Plan/Health Plan or Procedure		
Notes:		
.....		
Public Health Nurse Name _____	Public Health Nurse Signature _____	Date _____



EMERGENCY CARE INFORMATION

In case of an emergency, the school staff will contact 911.

Every attempt will be made to contact a parent, a guardian, or a designated emergency contact.

STUDENT INFORMATION					
Last:	First:	Middle:	Date of Birth:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> NB	Grade:
School Name:	ID No.:	Teacher or Counselor :		Bus # (AM):	Bus # (PM):
<input type="checkbox"/> Student has medical alert information on file. See page 2 for details.			Student Cell _____		

PARENT/GUARDIAN CONTACT INFORMATION

This form is to be completed by the enrolling parent. The enrolling parent is the natural or adoptive parent or legal guardian with whom the student lives the preponderance of the school week and who enrolled the student in school.

Enrolling Parent				Telephone
Last:	First:	Middle:		
Home:				
Number:	Street:	Apt.#:	Work:	
City:		State:	Zip:	Cell:
Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/> Self		<input checked="" type="checkbox"/> Resides with	Language:	E-mail:

Other Parent				Telephone
Last:	First:	Middle:		
Home:				
Number:	Street:	Apt.#:	Work:	
City:		State:	Zip:	Cell:
Relationship:		<input type="checkbox"/> Resides with	Language:	E-mail:

Other Parent				Telephone
Last:	First:	Middle:		
Home:				
Number:	Street:	Apt.#:	Work:	
City:		State:	Zip:	Cell:
Relationship:		<input type="checkbox"/> Resides with	Language:	E-mail:

Other Parent				Telephone
Last:	First:	Middle:		
Home:				
Number:	Street:	Apt.#:	Work:	
City:		State:	Zip:	Cell:
Relationship:		<input type="checkbox"/> Resides with	Language:	E-mail:

OTHER CONTACT INFORMATION

Please list at least two people we may call if the parent(s) or guardian(s) cannot be reached in the event of an emergency. These people also have your permission to pick your child up from school during the school day.

Name of Person	Relationship	Language	Telephone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

* Please remember to sign page 2.



EMERGENCY CARE INFORMATION

In case of an emergency, the school staff will contact 911.
Every attempt will be made to contact a parent, a guardian, or a designated emergency contact.

STUDENT INFORMATION					
Last:	First:	Middle:	Date of Birth:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> NB	Grade:
School Name:	ID No.:	Teacher or Counselor:	Bus # (AM):	Bus # (PM):	
Siblings attending the same school (complete if applicable). Name(s): _____ Name(s): _____			Primary Internet access in the home for this student is <input type="checkbox"/> Cellular <input type="checkbox"/> Broadband <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> Declined Do you have a device for this student to use that meets their educational needs? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined		

CURRENT HEALTH CONDITIONS	
Below check any current health condition(s) that EMS or an emergency room health care provider should know about health of your student. Also complete and submit Health Information form SS/SE-71 if your child has a health condition(s) that require(s) attention during the school day. See below for medical alert information currently on file.	
<input type="checkbox"/> allergies (be specific) <input type="checkbox"/> foods _____ <input type="checkbox"/> medicines _____ <input type="checkbox"/> bee sting or insect bite _____ <input type="checkbox"/> other _____ <input type="checkbox"/> asthma <input type="checkbox"/> cancer <input type="checkbox"/> diabetes <input type="checkbox"/> hearing problems <input type="checkbox"/> hearing aid(s) <input type="checkbox"/> heart problems (be specific) _____ _____ _____ _____	<input type="checkbox"/> hemophilia <input type="checkbox"/> sickle cell anemia <input type="checkbox"/> physical disability (be specific) _____ <input type="checkbox"/> respiratory (be specific) _____ _____ <input type="checkbox"/> seizures <input type="checkbox"/> vision problems (be specific) _____ <input type="checkbox"/> glasses <input type="checkbox"/> contacts <input type="checkbox"/> other (be specific) _____ _____ _____
List all medications and dosages your child receives on a continual basis: _____ _____ _____	

MEDICAL ALERT INFORMATION ON FILE
<div style="border: 1px solid black; padding: 20px; width: fit-content; margin: auto;"> This space reserved for system printing of Health Information </div>

HEALTH CARE PROVIDER INFORMATION	
My child's medical care is provided by: _____	_____ (telephone)
(name of health care provider or clinic)	
Does your child have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, medical coverage is provided by: _____	_____ (telephone)
(health insurance company, assistance program, HMO, etc.)	

First aid and emergency treatment will be provided to students in accordance with the current version of FCPS Regulation 2102 or in accordance with the student's individualized health plan.

ENROLLING PARENT OR GUARDIAN SIGNATURE: _____ DATE: _____



Parent Information About the Emergency Care Information Form

What is the Emergency Care Information form used for?

School staff rely on the Emergency Care Information form to provide them with information needed to (1) contact a parent or other responsible adult in the event of an emergency concerning the student; (2) assist school staff or emergency medical services in the event the student requires medical services for illness or injury; (3) respond to requests to release of the student during the school day in nonemergency situations.

Who is responsible for completing the Emergency Care Information form?

This form should be completed by the enrolling parent. The enrolling parent is the natural parent, adoptive or legal guardian with whom the student lives the preponderance of the school week and who enrolled the student in school.

Who else should be listed in the Parent/Guardian Contact Information section of the form?

The Parent/Guardian Contact Information section has space for a student's other natural or adoptive parent or legal guardian to be listed. A parent's contact information should be listed in the second box if the parent shares legal custody of the child with the enrolling parent. School staff will share information about the student and will release the student to a parent who has legal custody of the child. A stepparent that resides with the child may also be listed in the Parent/Guardian Contact Information section of the form.

Who should be listed in the Other Contact Information section of the form?

It is very important that school staff have contact information for at least two responsible adults who can be contacted in the event of an emergency when the parents cannot be reached. Other adult family members or friends should be listed in the Other Contact Information section of the form.

Please also note that school staff will allow any person you list on this form in the Other Contact Information section to pick up the child from school during the school day in both emergency and nonemergency situations.

In the event of an emergency, who will the school notify?

In the event of an emergency, school staff members will attempt to contact the enrolling parent first. If the enrolling parent cannot be reached, school staff will then attempt to reach the parent/guardian, if any. If neither the enrolling nor other parent/guardian listed can be reached, school staff shall contact the people listed in the Other Contact Information section on the Emergency Care Information form. Once a parent or designated contact is reached, staff will provide him or her with information about the student and the emergency situation and will release the student to him or her, as appropriate.

A noncustodial parent may be provided with information about the child, but staff will not release the student to him or her without the written consent of the custodial parent (Regulation 2240, III.B, and IV.F).

What should I do if I need to update the information on this form?

It is extremely important that school staff have the most up to date and accurate information about your child. The enrolling parent may update information on this form at any time by either contacting the school or accessing the [Online Verification/Update \(OVU\) packet](#) in SIS ParentVUE.

Where can I find more information about FCPS's procedures regarding the emergency care information form and first aid and emergency treatment for students?

Please refer to FCPS Regulation 2240, Parent Participation and Decision-making and FCPS Regulation 2102, First Aid, Emergency Treatment, and Administration of Medication for Students for additional information.

How do I change the phone number used for attendance and non-emergency calls?

Changes to the phone number used for attendance and non-emergency calls can only be made by contacting your child's school directly or using the [Online Verification/Update \(OVU\) packet](#) in SIS ParentVUE to make the change.



FAIRFAX COUNTY PUBLIC SCHOOLS
CRIMINAL CONVICTION AND JUVENILE DELINQUENCY
ADJUDICATION AFFIRMATION

Section 22.1-3.2 of the Code of Virginia requires that parents/guardians provide upon registration of students in public schools:

A sworn statement or affirmation indicating whether the student has been found guilty of or adjudicated delinquent for any offense listed in subsection G of Section 16.1-260 or any substantially similar offense under the laws of any state, the District of Columbia, or the United States or its territories.

These offenses are:

- A firearm offense
Homicide
Felony assault and bodily wounding
Criminal sexual assault
Manufacture, sale, gift, distribution or possession of Schedule I or II controlled substances
Manufacture, sale or distribution of marijuana
Arson and related crimes
Burglary and related offenses
Robbery
Prohibited street gang participation
Prohibited street gang activity
Recruitment of other juveniles for criminal street gang activity

Student Name _____ Date of Birth _____

Parent/Guardian Affirmation

I affirm that the above student has not been found guilty of or adjudicated delinquent for an offense listed above or any substantially similar offense under the laws of any state, the District of Columbia, or the United States or its territories.

I affirm that the above registered student has been found guilty of or adjudicated delinquent for an offense listed above or any substantially similar offense under the laws of any state, the District of Columbia, or the United States or its territories, as indicated below:

Type of Offense _____ Date of Offense _____ Jurisdiction Where Offense Occurred _____

Parent Signature _____ Date _____ Print Parent Name _____

SS/SE-219 (11/06)

REGISTRAR: DO NOT RETAIN IN CUM FOLDER. MAINTAIN ALL COMPLETED FORMS TOGETHER IN SEPARATE CONFIDENTIAL FILE. IF PARENT/GUARDIAN CHECKS SECOND STATEMENT, NOTIFY BUILDING ADMINISTRATOR, WHO MAY INITIATE REFERRAL TO FCPS HEARINGS OFFICE.

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

Part I – HEALTH INFORMATION FORM

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

Name of School: _____ Current Grade: _____

Student's Name: _____
Last First Middle

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

Student's Address _____ City _____ State _____ Zip Code _____

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

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

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

Hospital Preference: _____

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

Box 1. Pre-Existing Conditions					
Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex) Please list Life Threatening Allergies:			Diabetes: Type 1		
			Diabetes: Type 2		
			Insulin pump		
Allergies (seasonal)			Head injury, concussion		
Asthma or breathing conditions			Hearing conditions or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart conditions		
Behavioral/Psych/ Social conditions			Lead poisoning		
Developmental conditions			Muscle conditions		
Bladder conditions			Seizures		
Bleeding conditions			Sickle Cell Disease (not trait)		
Bowel conditions			Speech conditions		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental Health conditions			Vision conditions		
Describe any other important health-related information about your child <input type="checkbox"/> Feeding tube , <input type="checkbox"/> Trach , <input type="checkbox"/> Oxygen support, <input type="checkbox"/> Hearing aids, <input type="checkbox"/> Dental appliance, <input type="checkbox"/> Wheelchair, Hospitalizations, etc. :					

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

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

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

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

Signature of Parent or Legal Guardian: _____ Date: ___/___/___

Signature of Interpreter: _____ Date ___/___/___

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

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

Section I

See Section II for conditional enrollment and exemptions.

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

Student Name:	Date of Birth :	Sex:
Race (Optional):	Ethnicity: Hispanic Non-Hispanic	

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
	1	2	3	4	5
Diphtheria, Tetanus, Pertussis Vaccine DTP, DTaP					
Diphtheria, Tetanus DT or Tdap or Td Vaccine given after 7 years of age					
Tdap Vaccine booster					
Poliomyelitis Vaccine (IPV, OPV)					
Haemophilus influenzae Type b Vaccine (Hib conjugate only for children <60 months of age)					
Rotavirus Vaccine RV only for children < 8 months of age					
Pneumococcal Vaccine PCV conjugate only for children <60 months of age					
Varicella Vaccine			Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Measles, Mumps, Rubella Vaccine (MMR vaccine)					
Measles Vaccine Rubeola			Serological Confirmation of Measles Immunity:		
Rubella Vaccine			Serological Confirmation of Rubella Immunity:		
Mumps Vaccine			Serological Confirmation of Mumps Immunity:		
Hepatitis B Vaccine HBV <input type="checkbox"/> Merck adult formulation used					
Hepatitis A Vaccine					
Meningococcal ACWY Vaccine					
Meningococcal B Vaccine					
Human Papillomavirus Vaccine (HPV)					
Influenza Yearly					
Other					
Other					

Certification of Immunization	
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 <i>Regulations for the Immunization of School Children</i> Reference Section III .	
Signature of Medical Provider or Health Department Official: _____	Date (Mo., Day, Yr.): ___/___/___

Section II
Conditional Enrollment and Exemptions

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

Student's Name: _____ Date of Birth: ____ ____
 Parent or Legal Guardian Name: _____
 Parent or Legal Guardian Name: _____
 Phone Number: _____

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

DTP/DTPaP/Tdap : [____]; DT/Td:[____]; OPV/IPV:[____]; Hib:[____]; PCV:[____]; RV:[____]; Measles :[____];

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

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

Signature of Medical Provider or Health Department Official: _____ **Date *Mo., Day, Yr.*:** ____ / ____ / ____

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

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

Signature of Medical Provider or Health Department Official: _____ **Date *Mo., Day, Yr.*:** |____| |____| |____|

Section III Requirements

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

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

(Requirements are subject to change.)

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

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

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									
		1	2	3	1	2	3	1	2	3	
	HEENT				Neurological				Skin		
Lungs				Abdomen				Genital			
Heart				Extremities				Urinary			
Tuberculosis Screening											
Check the box that applies:											
<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"/> Negative <input type="checkbox"/> Positive CXR required if positive test for TB infection or TB symptoms. CXR Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal											
EPSDT Screens Required for Head Start – include specific results and date:											
Blood Lead: _____ Hct/Hgb _____											

Developmental Screen	Assessed for:	Assessment Method:	<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"/> Screened by OAE Otoacoustic Emissions : <input type="checkbox"/> Pass <input type="checkbox"/> Referred					
		1000	2000	4000		
	R				<input type="checkbox"/> Referred to Audiologist/ENT <input type="checkbox"/> Unable to test – needs rescreen <input type="checkbox"/> Permanent Hearing Loss Previously identified: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Hearing aid or another assistive device	
	L					

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				Dental Screen <input type="checkbox"/> Problems Identified: Referred for Treatment <input type="checkbox"/> No Problem: Referred for prevention <input type="checkbox"/> No Referral: Already receiving dental care <input type="checkbox"/> Unable to perform	
	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						

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: _____
Practice/Clinic Name: _____	Address: _____
Phone: _____ - _____ - _____	Fax: _____ - _____ - _____ Email: _____



Identification of Military Connected Students

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

Student Name _____ **Student Date of Birth** _____

Definition of Military Connected:

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

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

- No** If NO, stop here. You do not need to return this form.
- Yes** If YES, please indicate current status and return this form.

CHECK ONE:

- Parent is a member of a United States Active Component.
- Parent is a member of a United States Reserve Component.
- Parent is a member of the National Guard.
- Parent is no longer a member of the United States uniformed services.

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

- No** If NO, stop here. You do not need to return this form.
- Yes** If YES, please indicate current status and return this form.

CHECK ONE:

- Parent is a member of a United States Active Component.
- Parent is a member of a United States Reserve Component.
- Parent is a member of the National Guard.

Parent/Legal Guardian Name _____

Parent/Legal Guardian Signature _____ Date _____

RESIDENCY ATTESTATION

PURPOSE: To certify that I am the natural parent, the adoptive parent, or the legal guardian of the child or children I am enrolling in school and that we will be living together in Fairfax County on a permanent basis.

CERTIFICATION

I certify that I am currently residing with my child(ren) in Fairfax County at:

Number, Street

Apt. Number

City

VA
State

ZIP Code

I further certify that the documentation presented as proof of domicile in Fairfax County attests to my permanent move to Fairfax County.

I acknowledge that this statement is accepted in good faith by school officials, and I further understand that I could be responsible for the payment of tuition for the time my child(ren) attended Fairfax County Public Schools if I leave Fairfax County. **I shall notify the school if I leave the county for any length of time and leave my child(ren) in the care of a relative or other adult.**

I understand that providing false or otherwise untrue information for school enrollment purposes constitutes a Class 4 misdemeanor.

Student Name(s) _____

Print Parent or Guardian Name _____

Parent or Guardian Signature

Date

REQUEST FOR STUDENT RECORDS

Date: _____

Student Information

Last	First	Middle	Date of Birth
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Name of last school attended: _____

School Address: _____

The student listed above has enrolled at a school within Fairfax County Public Schools. We are respectfully requesting that you please mail, fax, or email the following records within 5 business days:

- Academic
- Discipline
- Health
- Legal
- English learner services (ELP/WIDA scores)

If the student has been identified as a student with a disability, please release the following additional information:

- 504 Qualification
- 504 Plan
- Current IEP
- Current special education eligibility
- Most recent evaluations (psychological, educational, sociocultural, or any related services assessments)

Request sent by: _____ Phone: _____

Parent/Guardian or School Official Signature

Date

Parental permission is not required when records are requested by authorized school personnel.

The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) is a Federal law that protects the privacy of student education records. However, FERPA allows schools to disclose those records, without consent, to the following parties or under the following conditions (34 CFR § 99.31): Other schools to which a student is transferring.

Please send to: _____

Address: _____

Email: _____

Fax: _____