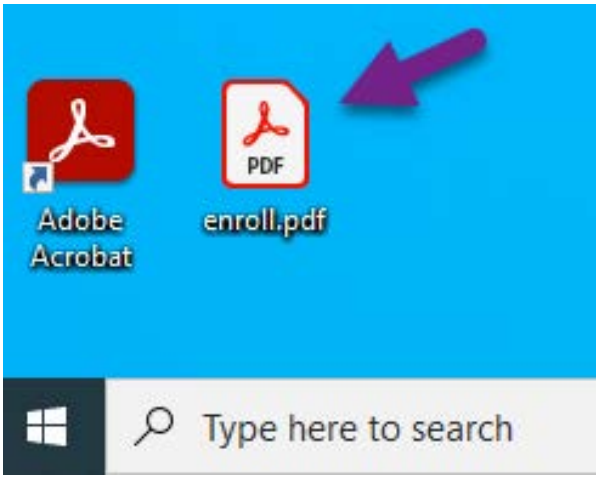
Fairfax County PUBLIC SCHOOLS
ENGAGE • INSPIRE • THRIVE

For students 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.



Click here to reset the student specific fields on these forms. Parent or Guardian information will not be affected by this RESET function.

Fairfax County PUBLIC SCHOOLS
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Student Registration Form
Part A

FCPS Student ID

Student Legal Name (as it appears on the birth certificate)
Last First Middle

Student Previous Name (if any)
Last First Middle

Student Nickname	Date of Birth (mm/dd/yyyy)	Student Home Telephone (ten digits) ☐ unlisted	Country of Birth	Gender ☐ Male ☐ Female ☐ 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
Street Apt No. City State Zip Code/Suffix

Dwelling Location (select only one)
☐ 5 City of Fairfax ☐ 9 Fairfax County ☐ 4 Fort Belvoir ☐ 6 Other (not Fairfax County)

Enrolling Parent
Relationship ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Self ☐ Caretaker
This box is only checked by Student Registration Staff.
Last First Middle

E-mail _____ Contact Numbers ten digits ☐ Unlisted Home _____ Work _____ Cell _____

In the event of an emergency, school staff members shall attempt to contact the enrolling parent first, and then the other custodial parent, if any. Under certain conditions, the enrolling parent/caregiver can be changed. Please review Regulation 2240, V., B. for more information and work with your school should this be necessary.

Other Parent Resides With ☐ Yes ☐ No
Relationship ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Stepmother ☐ Stepfather
Last First Middle Address (if different from above)

E-mail _____ Contact Numbers ten digits ☐ Unlisted Home _____ Work _____ Cell _____

Other Parent Resides With ☐ Yes ☐ No
Relationship ☐ Mother ☐ Father ☐ Legal Guardian ☐ Stepmother ☐ Stepfather
Last First Middle Address (if different from above)

E-mail _____ Contact Numbers ten digits ☐ 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

Click here to reset the student specific fields on these forms. Parent or Guardian information will not be affected by this RESET function.

Fairfax County PUBLIC SCHOOLS
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Student Registration Form
Part B

Last First Middle

Student Legal Name _____

FCPS Student ID

Number of Full Academic Years Completed in the U.S. in grades K-12
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

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?
☐ Yes ☐ No
If yes, how many years? _____

Ever Received a Service from FCPS Before?
☐ Yes ☐ No
Previous ID _____

Ever Attended FCPS Before?
☐ Yes ☐ No

If Yes, Name of Last School Attended in FCPS _____

Last Year Attended _____

Last School Attended NOT in FCPS

School Name

Street City State Zip Code

School Phone (ten digits) School Fax (ten digits)

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?

☐ 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 _____
Affidavit with Supporting Documentation Code _____

Date of Entry (current)
_____ E _____
_____ R _____

Original FCPS Entry Date

Original 9th Grade Entry Date

Student Assignment
Placement Code
Base School

Transportation
☐ Authorized to Ride Bus
☐ Not Authorized to Ride Bus

Proof of Address Received
Document Type(s) _____

Homeless
☐ Yes ☐ No

Tuition Code

Contact Restriction
☐ Yes ☐ No

Special Education Program Code
☐ 1 R ☐ 2 S

AAP Status

Counselor

Homeroom

Teacher

Current Enrolling FCPS School _____

FCPS Staff Signature _____ Date _____ Print Name _____

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Click here to reset the student specific fields on these forms. Parent or Guardian information will not be affected by this RESET function.

Fairfax County PUBLIC SCHOOLS
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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: ☐ Male ☐ Female ☐ 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	☐	☐ Foods: _____ ☐ Insect Sting: _____ ☐ Latex Epinephrine prescribed? ☐ Yes ☐ No Epinephrine injection previously given? ☐ Yes ☐ No If yes, date of injection: _____
Asthma	☐	Triggers: ☐ Exercise ☐ Environmental ☐ Upper Respiratory Infection ☐ Other: _____ Inhaler prescribed? ☐ Yes ☐ No Nebulizer Treatment prescribed? ☐ Yes ☐ No Number of Emergency Room (ER) Visits in the last calendar year: ____
Diabetes	☐	☐ Type 1 ☐ Type 2 Diagnosis Date: _____ Name of emergency medication: _____ Glucose Monitoring: ☐ Glucometer ☐ CGM Insulin Administration: ☐ Syringe ☐ Pen ☐ Pump
Seizures	☐	Type of Seizure: _____ Date of last seizure: _____ Emergency Medication Needed at school? ☐ Yes ☐ No VNS implanted? ☐ Yes ☐ 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)	☐	
Blood Disorder	☐	
Cancer	☐	Currently Immunocompromised ☐ Yes ☐ No
Cystic Fibrosis	☐	
Dental/Oral Health Condition	☐	
Ear, Nose & Throat Conditions	☐	Please specify:
Endocrine Disorder (other than Diabetes)	☐	
Food Intolerance	☐	Foods: _____ Gastrointestinal/Digestive Distress ☐ Yes ☐ No
Food/Dietary Preference	☐	
Gastrointestinal/Stomach/Bowel	☐	
Hearing Conditions	☐	
Heart/Cardiovascular	☐	
Kidney/Urinary Tract Disorders	☐	
Headache/Migraines	☐	
Lung Disease (other than Asthma)	☐	
Mobility Impairment	☐	

Click here to reset the student specific fields on these forms. Parent or Guardian information will not be affected by this RESET function.

Fairfax County PUBLIC SCHOOLS
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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	☐	Please specify:
Neurological (other than seizures)	☐	☐ Brain Injury/Concussion/Date Diagnosed: _____ ☐ Cerebral Palsy ☐ Other: _____
Skin Condition	☐	☐ Eczema ☐ Other: _____
Vision Conditions	☐	☐ Contacts/Glasses ☐ Non-Correctable ☐ Other: _____
Other Health Conditions	☐	☐ Autism ☐ Down Syndrome ☐ Other: _____
Emotional/Mental Health Conditions:		
ADD/ADHD	☐	Provider Diagnosed ☐ Yes ☐ No Under Treatment ☐ Yes ☐ No
Anxiety	☐	Provider Diagnosed ☐ Yes ☐ No Under Treatment ☐ Yes ☐ No
Depression	☐	Provider Diagnosed ☐ Yes ☐ No Under Treatment ☐ Yes ☐ No
Eating Disorder	☐	Provider Diagnosed ☐ Yes ☐ No Under Treatment ☐ Yes ☐ No
Other: _____	☐	Provider Diagnosed ☐ Yes ☐ No Under Treatment ☐ Yes ☐ No

Section E: Health Procedures:

The Fairfax County Health Department provides referral information to community medical resources providing free physical examinations. Visit https://www.fairfaxcounty.gov/health/clinics.

If your child has a health condition, does your child require any health procedures or need any special equipment during the school days?

☐ **Yes** ☐ **No** **If you answered Yes, please describe:** _____

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. ☐ Yes ☐ 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

☐ HIF Reviewed ☐ Follow Protocol (SH Care Emerg.-Temp. Care Guidelines) ☐ Health Condition List

☐ Mental Health Condition List ☐ Action Plan/Health Plan or Procedure

Notes: _____

_____

_____

_____

_____

_____ Public Health Nurse Name

_____ Public Health Nurse Signature

_____ Date

Click here to reset the student specific fields on these forms. Parent or Guardian information will not be affected by this RESET function.

Fairfax County PUBLIC SCHOOLS
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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: ☐ M ☐ F ☐ NB	Grade:

School Name:	ID No.:	Teacher or Counselor :	Bus # (AM):	Bus # (PM):

☐ 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 Last: First: Middle: Telephone Home:

Number: Street: Apt.#: Work:

City: State: Zip: Cell:

Relationship: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Self

☑ Resides with

Language:

E-mail:

Other Parent Last: First: Middle: Telephone Home:

Number: Street: Apt.#: Work:

City: State: Zip: Cell:

Relationship:

☐ Resides with

Language:

E-mail:

Other Parent Last: First: Middle: Telephone Home:

Number: Street: Apt.#: Work:

City: State: Zip: Cell:

Relationship:

☐ Resides with

Language:

E-mail:

Other Parent Last: First: Middle: Telephone Home:

Number: Street: Apt.#: Work:

City: State: Zip: Cell:

Relationship:

☐ 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.

Click here to reset the student specific fields on these forms. Parent or Guardian information will not be affected by this RESET function.

Fairfax County PUBLIC SCHOOLS
ENGAGE • INSPIRE • THRIVE

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: ☐ M ☐ F ☐ 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
☐ Cellular ☐ Broadband ☐ Other ☐ None ☐ Declined

Do you have a device for this student to use that meets their educational needs? ☐ Yes ☐ No ☐ 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.**

☐ allergies (be specific)
- ☐ foods _____
- ☐ medicines _____
- ☐ bee sting or insect bite _____
- ☐ other _____

☐ asthma
☐ cancer
☐ diabetes
☐ hearing problems ☐ hearing aid(s)
☐ heart problems (be specific) _____

_____

☐ hemophilia ☐ sickle cell anemia
☐ physical disability (be specific)

_____

☐ respiratory (be specific)

_____

☐ seizures
☐ vision problems (be specific) _____
- ☐ glasses ☐ contacts

☐ other (be specific)

_____

_____

List all medications and dosages your child receives on a continual basis:

_____

_____

_____

MEDICAL ALERT INFORMATION ON FILE

This space reserved for system printing of Health Information

HEALTH CARE PROVIDER INFORMATION

My child's medical care is provided by: _____ _____
(name of health care provider or clinic) (telephone)

Does your child have health insurance? ☐ Yes ☐ No

If yes, medical coverage is provided by: _____ _____
(health insurance company, assistance program, HMO, etc.) (telephone)

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: _____

Click here to reset the student specific fields on these forms. Parent or Guardian information will not be affected by this RESET function.

Fairfax County PUBLIC SCHOOLS
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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.

Click here to reset the student specific fields on these forms. Parent or Guardian information will not be affected by this RESET function.

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**
- **Felonious 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.

Click here to reset the student specific fields on these forms. Parent or Guardian information will not be affected by this RESET function.

Note: Print All Pages of the State Health Form

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 ☐ Feeding tube , ☐ Trach , ☐ Oxygen support, ☐ Hearing aids, ☐ Dental appliance, ☐ 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_____/_____/_____

Click here to reset the student specific fields on these forms. Parent or Guardian information will not be affected by this RESET function.

Note: Print All Pages of the State Health Form

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				
Diphtheria, Tetanus, Pertussis Vaccine DTP, DTaP	1	2	3	4	5
Diphtheria, Tetanus DT or Tdap or Td Vaccine given after 7 years of age	1	2	3	4	5
Tdap Vaccine booster	1				
Poliomyelitis Vaccine IPV, OPV)	1	2	3	4	5
Haemophilus influenzae Type b Vaccine (Hib conjugate only for children <60 months of age	1	2	3	4	
Rotavirus Vaccine RV only for children < 8 months of age	1	2	3		
Pneumococcal Vaccine PCV conjugate only for children <60 months of age	1	2	3	4	
Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Measles, Mumps, Rubella Vaccine MMR vaccine)	1	2			
Measles Vaccine Rubeola	1	2	Serological Confirmation of Measles Immunity:		
Rubella Vaccine	1	2	Serological Confirmation of Rubella Immunity:		
Mumps Vaccine	1	2	Serological Confirmation of Mumps Immunity:		
Hepatitis **B** Vaccine HBV ❑ Merck adult formulation used	1	2	3	4	
Hepatitis **A** Vaccine	1	2			
Meningococcal **ACWY** Vaccine	1	2			
Meningococcal **B** Vaccine	1	2	3		
Human Papillomavirus Vaccine (HPV	1	2	3		
Influenza Yearly	1	2	3	4	5
Other	1	2	3	4	5
Other	1	2	3	4	5

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 *Regulations for the Immunization of School Children* Reference Section III .

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

Click here to reset the student specific fields on these forms. Parent or Guardian information will not be affected by this RESET function.

Note: Print All Pages of the State Health Form

Section II
Conditional Enrollment and Exemptions

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

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

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

_____

_____

_____

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

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

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

Signature of Medical Provider or Health Department Official:_____Date *Mo., Day, Yr.*):___/___/___

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

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

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

Section III Requirements

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

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

Click here to reset the student specific fields on these forms. Parent or Guardian information will not be affected by this RESET function.

Note: Print All Pages of the State Health Form

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

[illegible] 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				

Tuberculosis Screening

Check the box that applies:

☐ 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: ☐ Negative ☐ Positive

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.

❑ Screened by OAE Otoacoustic Emissions : ☐ Pass ☐ Referred

	1000	2000	4000
R			
L			

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

☐ Permanent Hearing Loss Previously identified: ☐ Left ☐ Right

☐ Hearing aid or another 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

☐ Problems Identified: Referred for Treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

☐ **Unable to perform**

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::_____

____In**dividualized 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:**_____

M **Practice/Clinic Name:** _____ **Address:**_____

Phone:_____-_____-_____ **Fax:** _____-_____-_____ **Email:**_____

Click here to reset the student specific fields on these forms. Parent or Guardian information will not be affected by this RESET function.

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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 Active Service:** Full-time service.
- **National Guard Reserve:** Part-time service.

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 Active Service.

☐ Parent is a member of the National Guard Reserve.

☐ 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 Active Service.

☐ Parent is a member of the National Guard Reserve.

Parent/Legal Guardian Name _____

Parent/Legal Guardian Signature _____ Date _____

Click here to reset the student specific fields on these forms. Parent or Guardian information will not be affected by this RESET function.

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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**

Click here to reset the student specific fields on these forms. Parent or Guardian information will not be affected by this RESET function.

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Pre-Kindergarten Experience

Student Name _____ **Date of Birth** _____

The Virginia Department of Education requires FCPS to collect pre-kindergarten data for statistical purposes. Fairfax County Public Schools (FCPS) is gathering some additional information to support transition to kindergarten.

1. **Did your child attend a FCPS preschool or Fairfax County Government sponsored preschool program? (this does not include FCPS HIPPY, Early Literacy and Family Literacy Programs)**
   - **a.** ☐ Yes ***(Stop here. The form is now complete.)***
   - **b.** ☐ No ***(go to question 2 after completing)***

2. **Did your child have a preschool experience in the year prior to entering kindergarten?**
   - a. ☐ **Yes**- my child spent the day in a public preschool, private preschool, preschool in a home or daycare setting, etc. (This includes special education services provided in the home, hospital, or community.) ***(go to question 3 after completing)***
   - b. ☐ **No**- my child has not had a formal classroom preschool experience and was at home with a parent, family member, caregiver, nanny, etc. (Students who ONLY participated in a program such as HIPPY, Early Literacy, and Family Literacy should check this response) ***(go to question 7 after completing)***

3. **Please check one category that most accurately describes your child's most recent preschool experience. If your child attended more than one program, please select the primary program:** ***(go to question 4 after completing)***

Category	Definition	Check One
Head Start (Community-Based)	The student spends the day in a preschool classroom for four-year-olds funded by the federal Head Start grant in a community-based organization.	☐
Public Preschool	The student spends the day in a preschool program operated in the public school OR publicly funded preschool, including subsidized programs offered in the community or special education services provided in the home or other setting.	☐
Private Preschool/Daycare	The student spends the day in a preschool, child daycare, or other program operated by a private provider. This includes programs for-profit and nonprofit providers, including faith-based programs and commercial daycare centers.	☐
Department of Defense Child Development Program	The student spends the day in a program operated by the Department of Defense on a military installation.	☐
Family Home Daycare Provider	The student spends the day in a preschool or child daycare provided in a home.	☐

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Pre-Kindergarten Experience

4. **Please indicate how much time your child spent per week in the program checked above:**
   (go to question 5 after completing)

	Check One
0-14 hours per week	☐
15-29 hours per week	☐
30 or more hours per week	☐

5. **Did your child receive special education services the year prior to kindergarten?**
   a. ☐ Yes ***(go to question 6 after completing)***
   b. ☐ No ***(go to question 6 after completing)***

6. **Preschool Name** (optional) _____
   (Stop here. The form is now complete.)

---

7. **Did you live in Fairfax County, Virginia the year prior to your child starting kindergarten?**
   a. ☐ Yes ***(go to question 8 after completing)***
   b. ☐ No ***(Stop here. The form is now complete.)***

8. **FCPS is committed to removing any barriers that might prevent families from accessing preschool. Your response to this question will help us better understand how we can support every family effectively. Please identify any barrier(s) that may have prevented your child from attending preschool. Select up to three reasons.**
   a. ☐ Preference: No barriers, I preferred keeping my child home.
   b. ☐ Cost: Preschool was too expensive.
   c. ☐ Location: Preschool programs were not conveniently located near home or work.
   d. ☐ Transportation: There were challenges getting to and from preschool programs.
   e. ☐ Capacity: Preschool programs were fully enrolled and/or had waiting lists.
   f. ☐ Hours: Preschool program operating hours did not fit my family's needs.
   g. ☐ Finding Preschool: My family did not have the time, information, or resources to find a preschool program.
   h. ☐ Language: Preschool programs were not available in the language needed for my child and/or family.
   i. ☐ Other Needs: Preschool programs were not available to meet my child's needs (e.g., health needs, educational needs, etc.).
   j. ☐ Quality: Preschool programs were not high quality.
   k. ☐ Age: I felt my child was too young to be in school.
   l. ☐ Other/I prefer not to respond.