Fairfax County PUBLIC SCHOOLS
ENGAGE • INSPIRE • THRIVE

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)
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 | 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)
☐ City of Fairfax ☐ Fairfax County ☐ Fort Belvoir ☐ Other (not Fairfax County)
☐ Town of Clifton ☐ Town of Herndon ☐ Town of Vienna

Enrolling Parent
Last First Middle
Relationship ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Self

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

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

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

Other Parent Resides With ☐ Yes ☐ No
Last First Middle
Relationship ☐ Mother ☐ Father ☐ Legal Guardian ☐ Stepmother ☐ Stepfather
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.

Fairfax County PUBLIC SCHOOLS
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Student Registration Form
Part B

Last First Middle

FCPS Student ID

Student Legal Name _____

Number of Years Previously in K-12	Number of Full Academic Years Completed in U.S.	Ever Received a Service from FCPS Before?	Ever Attended FCPS Before?	Name of Last School Attended in FCPS	Last Year Attended
	☐ 0 ☐ 2 ☐ 4 or more ☐ 1 ☐ 3	☐ Yes ☐ No Previous ID _____	☐ Yes ☐ No		

Last School Attended NOT in FCPS

School Phone (ten digits)

School Name

Street City State Zip Code

School Fax (ten digits)

Country of Birth

☐ 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 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, including contacting landlords, 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	Date of Entry (current)	Original FCPS Entry Date	Original 9th Grade Entry Date	Student Assignment	
				Placement Code	Base School
Birth Certificate Number _____	_____ E _____				
Affidavit with Supporting Documentation Code _____	R _____				

Transportation	Proof of Address Received	Homeless	Tuition Code	Contact Restriction
☐ Authorized to Ride Bus ☐ Not Authorized to Ride Bus	Document Type(s) _____	☐ Yes ☐ No		☐ Yes ☐ No

Special Education Program Code		AAP Status	Counselor	Homeroom	Teacher
	☐ R ☐ S				

Current Enrolling FCPS School _____

FCPS Staff Signature _____ Date _____ Print Name _____

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Fairfax County PUBLIC SCHOOLS
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HEALTH INFORMATION

Complete this form annually to inform us about your student's health condition that affects his or her 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 educational record and is securely stored in the health room. 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)
Allergies (non-life threatening)	☐	
Blood Disorder	☐	
Cancer	☐	Currently Immunocompromised ☐ Yes ☐ No
Cystic Fibrosis	☐	
Dental/Oral Health Condition	☐	
Ear, Nose & Throat Conditions	☐	
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	☐	

Fairfax County PUBLIC SCHOOLS
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HEALTH INFORMATION

Complete this form annually to inform us about your student's health condition that affects his or her school day

Last Name _____ **First Name** _____ **Date of Birth**

Section D: Current Health Conditions, Continued:

Condition	Check if Yes	Comment
Muscle/Bone/Joint/Arthritis	☐	
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's 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:

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 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 (Medical Flag)

☐ Action Plan/Health Plan or Procedure

Notes:

.....

.....

.....

.....

_____ Public Health Nurse Name

_____ Public Health Nurse Signature

_____ Date

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 conta ct.

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.

EMERGENCY CARE INFORMATION

Fairfax County PUBLIC SCHOOLS
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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 cont act.

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: _____

Fairfax County
PUBLIC SCHOOLS
ENGAGE • INSPIRE • THRIVE

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 weCare@school in the FCPS 24-7 website (fcps.blackboard.com).

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 and specifying that you wish to have the student home phone number changed.

Fairfax County PUBLIC SCHOOLS
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HOME LANGUAGE SURVEY

Student Name _____ Date of Birth _____
Last First Middle

Parent(s) or Guardian(s): Federal guidelines require school divisions to identify students who are potential English learners (ELs). If the answers to the following questions indicate that a language other than, or in addition to, English is spoken in the home, the student's English language proficiency will be evaluated to ensure that services are offered to students who need them. Based on the results of these assessments, students are found English proficient or eligible for ESOL services.

Please answer the questions completely and accurately.

1. What is the primary language used in the home, regardless of the language spoken by the student?

   Which language? _____

2. What is the language most often spoken by the student?

   Which language? _____

3. What is the language that the student first acquired?

   Which language? _____

In which language do you prefer to receive communication from the school?

Which language? _____

First Last

_____ ____/____/____ _____
Parent or Guardian Signature Mo. Day Yr. Print Name

FCPS Staff Members: This form must be completed for <u>all</u> students registering in Fairfax County Public Schools. It should be the first document provided to parent(s)/guardian(s) during the registration process. If there is a language other than, or in addition to, English indicated for any of the three questions, enter this language in the student information system. Please make sure that all questions are answered completely.

Students with a language other than, or in addition to, English should be referred to student registration for registration and assessment. Students entering kindergarten with a language, other than or in addition to, English may be registered at their base school prior to the beginning of the school year. Starting on the first day of school, kindergarten students with a language other than, or in addition to, English should be referred to student registration for registration and assessment.

If the parent(s)/guardian(s) have a question about this form, please refer them to a school administrator or contact the ESOL Assessment Center at 703-204-4375.

FAIRFAX COUNTY PUBLIC SCHOOLS
CRIMINAL CONVICTION AND JUVENILE DELINQUE NCY 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.

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: None7 FAMIS Plus (Medicaid) 7 FAMIS 7 Private/Commercial/ Employer Sponsored7 _____

Box 1. Pre-Existing Conditions

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes: Type 1		
Please list **Life Threatening Allergies**:			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 7 Feeding tube , 7 Trach , 7 2xygen support, 7 Hearing aids, 7 Dental appliance, 7 Wheelchair, Hospitalizations, etc.):

Box 2. Medications

List all prescription, emergency, over-the-counter, and herbal medications your child takes regularly (Home/ School):

Medication Name	'osage	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. ☐ ☐ 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 ____/____/____

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 **ADE4UATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIM8M 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 (*0o., 'ay, Yr.*): BBB/___/BBBB**

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.*): I___ I_____I____I.

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 RELIGIO8S E;EMPTION (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.*):I___I___I___I

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.)

Note: Print All Pages of the State Health Form

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

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

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

Health Assessment

Date of Assessment: ____/____/_____

Weight:_____lbs. Height:_____ft._____in.

Body Mass Index (BMI):_____BP_____

☐ Age / gender appropriate history completed

☐ Anticipatory guidance provided

Physical Examination

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

	1	2	3		1	2	3		1	2	3	
HEENT				Neurological				Skin				
Lungs				Abdomen				Genital				
Heart				Extremities				8rinary				

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-in}ector* ☐ other::_____

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

____**Restricted Activity Specify:** :_____

____**Developmental Evaluation** ☐ Has IEP ☐ Further evaluation needed for: _____

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

____**Special Diet Specify:** _____

____**Special Needs Specify:**_____

Other Comments:_____

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

Name:_____ **Signature:**_____

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

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

Identification of Military Connected Students

Fairfax County PUBLIC SCHOOLS
ENGAGE • INSPIRE • THRIVE

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 _____

REQUEST FOR STUDENT RECORDS

Date: _____

Student Information

Last	First	Middle	Date of Birth

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: _____

Last Updated: Jul 15, 2022

Printable Permission Form
Digital Resources at Fort Belvoir Primary

This letter is sent home in compliance with the Family Educational Rights and Privacy Act (FERPA) to provide you with information about the measures FCPS takes to keep student data secure when using digital tools. By signing this form, you provide permission for your child to use the FCPS-approved online tools listed below as part of an instructional program.

Fairfax County Public Schools uses a variety of resources to support student learning. In cases where FCPS contracts with a vendor to host student information, FCPS requires that the vendor adhere to the security and privacy requirements specified in a confidentiality agreement included in their contracts. FCPS does not have contracts with every instructional tool vendor. Many valuable instructional tools are governed by Terms of Service (TOS) and include both free and paid tools. Some of the digital resources your child may use this year require parental consent.

Listed below are the digital tools that are used at your child's school that require parental approval, and not all tools will be used by every student. The tools have been carefully reviewed to ensure that they align with the FCPS Learning Model and FCPS conducts the same technical evaluations for all products that use student information. These entities may have access to certain information from your child's education record, necessary to providing their functions, including, but not limited to, directory information as designated in the Fairfax County Public Schools Student Rights and Responsibilities, along with any student work that is created on the respective applications.

For information about the specific tools that will be used by your child, please contact your child's teachers. You will be notified if additional tools are added to this list and given the opportunity to opt-in to tools that require parental permission. Additionally, FCPS may use digital tools that do not collect, use or share any personal information.

You can find more information about FCPS' commitment to student privacy at https://www.fcps.edu/resources/technology/digital-citizenship-internet-safety/digital-privacy-fcps and a list of all approved digital tools is viewable online in the FCPS Digital Ecosystem Library (https://del.fcps.edu/) which has links to the vendors' privacy notices and other useful information.

This permission will expire at the end of this school year, and can be revoked at any time by contacting the school. If you have questions about any of the digital resources listed below, please contact your child's school.

Please indicate your choice, sign, and return this document to your child's school, or fill in the PDF and email the form to lndamico@fcps.edu from the email address you have registered in ParentVUE. This will serve as your permission for your student to have access to these tools. You may keep the list of digital tools for future reference.

☐ I consent to allow my child to use the digital resources listed below.

☐ I do not consent to allow my child to use one or more of the digital resources listed below. (*Please provide any comments below and someone from the school will contact you to discuss specific questions or concerns*.)

Comments_____

This permission will expire at the end of this school year, and can be revoked at any time by contacting the school. If you have questions about any of the digital resources listed above, please contact your child's school

Student First and Last Name	
FCPS Student ID	
Grade Level	
Parent / Guardian First and Last Name	
Signature of Parent / Guardian	
Date	