Pre-Kindergarten Registration

In Person Registration

1. In person registration will be held at each Pulaski County Public Elementary School on the following dates:

• Dublin Elementary School	February 25th 4-7 pm
• Pulaski Elementary School	March 4th 4-7 pm
• Riverlawn Elementary School	March 11th 4-7 pm
• Snowville Elementary School	March 18th 4-7 pm
• Critzer Elementary School	March 25th 4-7 pm

2. All mitigation strategies will be implemented, including but not limited to, wearing masks, physical distancing, and temperature checks.

3. Please bring the following items at the time of your appointment:

   - _____Verification of residence (utility bill, dish network bill, lease)
   - _____Verification of Income (W2's, Tax return, 3 Pay stubs)
   - _____Birth certificate; the school will make a copy
   - _____Health/Immunization records provided/copied
   - _____Enrollment packet returned/complete
   - _____Parent requests to see the nurse - take down parent information and nurse will reach out to parent at a different time
   - _____ Copy of Custody documents

Online Registration

1. These are fillable PDF documents. You will need to download the document to your desktop.
2. Complete them to the best of your ability and save the document with changes. Please send all documents and enrollment forms to sarnett@pcva.us
3. Submit a copy of the documents listed above in step 3
4. If there are items missing from your application or other questions, the school will be in contact with you.
5. It is important that all information given is accurate.
6. When all documents are received, you will be contacted by the Supervisor of Preschool to complete the application process. **Filling out the application does not guarantee a place in the program.**

Kindergarten Registration

In Person Registration

1. In person registration will be held at **each** Pulaski County Public Elementary School on **March 10, 2021 between 12 noon and 7PM**. Please call your child's school of attendance to make an appointment.
    - All mitigation strategies will be implemented, including but not limited to, wearing masks, physical distancing, and temperature checks.
2. Please bring the following items at the time of your appointment,
    - _____Proof of residence
    - _____Birth certificate; the school will make a copy
    - _____Health/Immunization records provided/copied
    - _____Enrollment packet returned/complete
    - _____Parent requests to see the nurse - the school will take parent information and nurse will reach out to parent at a different time
    - _____ Copy of Custody documents

    To expedite this process, the application is available online for printing at pcva.us

Online Registration

1. These are fillable PDF documents. You will need to download the document to your desktop.
2. Complete them to the best of your ability and save the document with changes. Please send all documents and enrollment forms to sarnett@pcva.us
3. The online application for both Pre-K and kindergarten students can be found at pcva.us
4. If there are items missing from your application or other questions, the school will be in contact with you
5. It is important that all information given is accurate.

For Enrolling Kindergarten Students Only

Please fill out the following information

Is this application for Pre-k or kindergarten?

Did your child attend a pre-school before attending kindergarten?

Yes ☐ No ☐

If yes, please give the name of the pre-school: _____

Please check the type of program they attended:

☐ Coordinated Pre-K classroom ☐ Virginia Preschool Initiative

☐ Head Start ☐ Coordinated Special Education

☐ Government – Tuition charges ☐ Private Provider

☐ Title 1 Pre K ☐ Special Education Only

☐ Licensed Home Daycare ☐ No formal or institutional PK

Other

Pre school weekly time:

☐ No time in formal Pk program

☐ Less than 15 hours per week

☐ 15 hours or more, but less than 30 hours per week

☐ 30 or more hours per week

Pulaski County Public Schools
Reach Each Child

School Readiness/Transitions Check-In

Welcome to the new school year! We are checking in with you to learn about your student's strengths and needs for support at school. By answering these questions, you can help us start the year off right!

Student Name:_____ Date: _____ Guardian Name:_____

Please rate your child in the following strengths:	**Doing Great** ☺	**Some Concern** 😐	**Serious Concern** ☹	**Need Support?**
Cooperates with adults	○	○	○	○
Behaves well at school	○	○	○	○
Gets grades that are appropriate for his/her skill level	○	○	○	○
Has good relationships with other students	○	○	○	○
Follows classroom rules	○	○	○	○
Focuses and stays on task in class	○	○	○	○
Completes homework and assignments on time	○	○	○	○
Shows up on time to school or other activities	○	○	○	○
Please rate your child in the following areas of concern:	**No Concern** ☺	**Some Concern** 😐	**Serious Concern** ☹	**Need Support?**
Avoids tasks that seem difficult or challenging	○	○	○	○
Spends time with students who you consider to be bad influences	○	○	○	○
Getting depressed, anxious, or irritable	○	○	○	○
Is easily distracted	○	○	○	○
Needs structure and supervision to stay on task and behave well	○	○	○	○
Likes attending school	○	○	○	○

Please list the support services that your student previously received:

_____

_____

Directory Information – Supplemental Form

If you selected Option B on the Directory Information form, please review the options below and provide additional clarification, if you so desire.

Not providing consent to the Directory Information form means that your child can not be listed in any publications, including the yearbook, playbills, the school's honor roll list, etc.

You may use the form below to allow for select use of your child's photograph and directory information for specific school division purposes.

I give permission for my child's photograph and directory information to be used for the following school division purposes:

- ☐ Extracurricular and Athletic Programs
- ☐ Graduation Lists
- ☐ Honor Roll
- ☐ Newspaper articles
- ☐ PTA Newsletter
- ☐ Social Media
- ☐ Television Stories
- ☐ Yearbook

If you select none of these options, this form is not necessary.

Student's Name: [OTHER IDENTIFIER]:

Child's Grade: Classroom Teacher:

Parent/Guardian Printed Name:

Parent/Guardian Signature:

DIRECTORY INFORMATION

The Family Education Rights and Privacy Act (FERPA) requires that Pulaski County Public Schools obtain your written consent prior to the disclosure of personally identifiable information from your child's education records. However, Pulaski County Public Schools may disclose appropriately designated directory information without written consent, unless you have opted out using the form below. The primary purpose of directory information is to allow Pulaski County Public Schools to include this type of information in certain school publications, such as

- School publications such as yearbooks and newspapers
- Articles about school activities and athletic events
- News of performances, school activities and athletic events
- Extracurricular and athletic programs
- Class lists and graduation lists
- Lists of those receiving honors, awards, scholarships
- Social media postings

Directory information, which is information that is generally not considered harmful or an invasion of privacy if released, can also be disclosed to outside organizations without a parent's prior written consent. Outside organizations include, but are not limited to, companies that manufacture class rings or publish yearbooks. In addition, federal law requires that Pulaski County Public Schools provide military recruiters, upon request, with three directory information categories – names, addresses and telephone listings – unless a parent has opted out using the form below.

Directory Information may include the following:

- Student's name
- Address
- Telephone listing
- Date and place of birth
- Major field of study
- Dates of attendance
- Participation in officially recognized activities and sports
- Photos or videos of performances, school activities and athletic events
- Weight and height of members of athletic teams
- Degrees, honors, and awards received
- The most recent educational agency or institution attended

DIRECTORY INFORMATION CONSENT FORM

Please check the appropriate box above to indicate your preference for release of directory information pertaining to your child. You may change your preference at any time by submitting a written request to the school office. Your child's school principal can answer any questions regarding FERPA and consent. This form must be submitted to the school by the first school day of September.

A. ☐ consent to the release of the above directory information about the student named below.

B. ☐ **do not** consent to the release of the above directory information about the student named below, except as authorized by law.

C. ☐ Grades 9-12 only) I consent to the release of the above directory information about the student named below **except** information about this student may **not** be released to the military.

Student's Name: [OTHER IDENTIFIER]:

Parent/Guardian Printed Name:

Parent/Guardian Signature:

PULASKI COUNTY PUBLIC SCHOOL DISTRICT
202 N. Washington Ave.
Pulaski, VA 24301

IT Acknowledgment and Consent Form

Students

I understand and agree to abide by the School Division's Acceptable Computer System Use Policy and Regulation. I understand that the School Division may access and monitor my use of the computer system, including, but not limited to, my use of the Internet, e-mail and downloaded material, without prior notice to me. I further understand that should I violate the Acceptable Use Policy or Regulation, my computer system privileges may be revoked and disciplinary action and/or legal action may be taken against me.

Printed Name of Student _____ Signature of Student _____

Date _____ Student Number _____

School _____ Grade _____

Parent(s)/Guardian

I have read this Agreement and Policy IIBEA/GAB and Regulation IIBEA-R/GAB-R. I understand that access to the computer system is intended for educational purposes and the Pulaski County School Division has taken precautions to eliminate inappropriate material. I also recognize, however, that it is impossible for the School Division to restrict access to all inappropriate material and I will not hold the School Division responsible for information acquired on the computer system. I have discussed the terms of this agreement, policy and regulation with my student.
I grant permission for my student to use the computer system in accordance with Pulaski County Public School's policies and regulations and for the School Division to issue an account for my student.

Printed Name of Parent/Guardian _____ Signature of Parent/Guardian _____

Date _____

Parental Notification and Responsibility

The School District will notify the parents about the School District IT systems and the policies governing their use. This policy contains restrictions on accessing inappropriate material. A wide range of material is available on the Internet, some of which may not fit with the particular values of the families of the students. It is not practically possible for the School District to monitor and enforce a wide range of social values in student use of the Internet. Further, the School District recognizes that parents bear primary responsibility for transmitting their particular set of family values to their children. The School District strongly encourages parents to specify to their child(ren) what material is and is not acceptable for their child(ren) to access through the School's District's IT system.

Military Status

Dear Parent/Guardian:

The 2015 Virginia General Assembly passed legislation (HB2373 and SB1354) that requires the Department of Education to establish identification of services-connected students.

Please complete the form below.

Student Name:

- ☐ Student is not military connected .
- ☐ Active duty; student is a dependent of a member of the Active Duty Forces (Army, Navy, Air Force, Marine Corps, Coast Guard, or National Guard, the Commissioned Corps of the National Oceanic and Atmospheric Administration, or the Commissioned Corps of the U.S. Public Health Services)
- ☐ Reserve; Student is a dependent of a member of the National Guard or Reserve; Student is a dependent of a member of the National Guard or Reserve Forces (Army, Navy, Air Force, Marine Corps, Coast Guard, or National Guard)

Parent(s)/Guardian(s) name(s) for code(s) listed above:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Home Language Survey

This survey must be completed for each new kindergarten and incoming student in grades K – 12 in Pulaski County Public Schools.

To make sure that all students receive the education services they need, the law requires us to ask questions about students' language backgrounds. The answers to Section A below will tell us if a student's proficiency in English should be evaluated and help us to ensure that important opportunities to receive programs and services are offered to students who need them. The answers to Section B below will help us communicate with you regarding the student and all school matters in the language you prefer. This form must be kept in the student's file.

Student's Name: Date of Birth:

School:

SECTION A: Please answer the questions below.

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?

_____

Parent/Guardian Signature: _____ Date: _____

SECTION B: Please answer the questions below.

1. In which language do you prefer to receive **written** school communications? (Write only one.)

_____

2. In which language do you prefer to receive **oral** school communications? (Write only one.)

_____

8/18

Pulaski County Public Schools
Reach Each Child

Cuestionario Sobre la Vivienda del Estudiante
CONFIDENCIAL

Nombre de la escuela: _____ Año escolar: _____

Nombre del estudiante: _____
apellido primer nombre segundo nombre

Fecha de nacimiento: ____/____/____ Edad: _____ Grado: _____ Genero: ◯ Masculino ◯ Femenino
mes / día / año

Este cuestionario tiene el objetivo de abordar con la Ley *McKinney-Vento Act 42 U.S.C. 11435*. Las respuestas a este cuestionario de residencia ayudan a determinar los servicios a que el alumno puede tener el derecho.

1. ¿Es la dirección actual del estudiante una situación de vivienda temporal (no fija)? ◯ Sí ◯ No
2. ¿Es esta situación debido a pérdida de hogar o resultado de problemas económicas? ◯ Sí ◯
3. ¿Es el estudiante un joven sin acompañante (no vive bajo la custodia de un padre o guardián legal)? ◯ Sí ◯ No
4. ¿Está el estudiante viviendo en un hogar de crianza *(Foster Care)*? ◯ Sí ◯ No

Si respondio SI a cualquiera de las preguntas anteriores, por favor complete el resto de este formulario. Si usted respondió NO, puede detenerse aquí y simplemente firmar el formulario al pie de esta hoja.

¿Dónde reside el estudiante actualmente?

- ☐ Está compartiendo vivienda con más de una familia o parientes (además de los padres)
- ☐ Vive en un albergue o refugio temporal
- ☐ Vive en un hotel
- ☐ Se mueve de un lugar a otro
- ☐ Vive en un lugar no diseñado para alojamiento fijo como un automóvil, un parque, o un campamento
- ☐ Vive en condiciones de vivienda inadecuada o deficiente
- ☐ En espera de un hogar de crianza *(Foster Care)*(temporal o de emergencia)
- ☐ Vive en un hogar de crianza otorgado (*Foster Care*)
- ☐ Vive con padrastros, abuelos, parientes o un cuidador que NO es su guardián legal
- ☐ Vive con amistades o solo/sola
- ☐ Otro: (Por favor describa)

Nombre de la persona que vive en el hogar responsable del estudiante

_____

Relación (marque una): ☐ Padre ☐ Guardián legal ☐ Hogar de Crianza (Foster Care) ☐ Si mismo
☐ Cuidador (incluye abuelos, padrastros, parientes, u otros adultos que no son guardianes legales)

Dirección_____ Código postal _____ Teléfono_____

¿Cuánto tiempo tiene viviendo en este lugar?_____
Otra información de contacto: _____

¿Tiene el estudiante hermanos de cualquier edad? Si es así, por favor de listar su(s) nombre(s) y su(s) edad(es):

_____

_____

Información sobre el Hogar de Crianza *(Foster Care)* (si aplica): Agencia de colocación_____

Condado de padres biológicos_____ Nombre del asistente del caso:_____

Entiendo que el estudiante mencionado anteriormente puede ser elegible para recibir servicios basados en la ley *McKinney-Vento Act 42 U.S.C. 11435*. Puedo ser contactado por un oficial de la escuela para obtener información adicional. También me puedo comunicar con el departamento de consejería en la escuela de mi hijo o del coordinador del progama de personas sin hogar para más información.

Firma _____ Fecha_____

Office Use: If the answer is "yes" to any of the first four questions, please email a copy to Office of Homeless at mchevert@pcva.us.
Original should be maintained at the home school.

Student Residency Questionnaire
CONFIDENTIAL

Pulaski County Public Schools
Reach Each Child

Name of School _____ School Year: _____

Name of Student: _____
Last First Middle

Birth Date ____/____/____ Age: _____ Grade: _____ Sex: ☐ Male ☐ Female
Month / Day / Year

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency questionnaire help determine the services the student may be eligible to receive.

1. Is the student's current address a temporary living arrangement? ◯ Yes ◯ No
2. Is this living arrangement due to loss of housing or financial difficulties? ◯ Yes ◯ No
3. Is the student unaccompanied (living in a household where no one is the parent or legal guardian.)? ◯ Yes ◯ No
4. Is the student in Foster Care? ◯ Yes ◯ No

If you answered *YES* to any of the above questions, please complete the remainder of this form. If you answered *NO*, you may stop here and just sign the form at the bottom of this sheet.

Where is the student presently living?

- ☐ Doubled up with more than one family or relative
- ☐ In a shelter
- ☐ In a motel
- ☐ Moving from place to place
- ☐ In a place not designed for ordinary sleeping accommodations such as a car, park, or campsite
- ☐ In housing that is inadequate or substandard.
- ☐ Awaiting foster care placement (could be temporary or emergency placement).
- ☐ In foster care with a qualified foster care family
- ☐ With a stepparent, grandparent, relative, or caretaker that is NOT a legal guardian
- ☐ With friend(s) or alone.
- ☐ Other: (Please describe.)

Name of person living in household responsible for this student _____

Relationship (check one): ☐ Parent ☐ Legal Guardian ☐ Foster Parent ☐ Self ☐ Caretaker (includes grandparent, stepparent, relative, or other adult that is not a legal guardian)

Address _____ Zip _____ Phone _____

How long have you lived at this location? _____

Other contact information: _____

Does this student have siblings of any age? If so, please list name(s) and age(s): _____

_____

Foster Care Information (if applicable): Placing Agency _____

County of Biological Parents _____ Name of Caseworker _____

I understand that the student listed above may be eligible for services based on McKinney-Vento Act 42 U.S.C. 11435. I may be contacted by a school official for additional information. I may also contact the guidance department at my student's school or the Homeless Liaison for more information.

Signature _____ Date _____

Office Use: If the answer is "yes" to any of the first four questions, please email a copy to Office of Homeless Liaison at mchevert@pcva.us.

Original should be maintained at the home school.

Pulaski County Public Schools
Student Enrollment and Registration Form

1. Country of Birth:

2. Immigrant: Yes ◯
No ◯

(An immigrant is a person that comes to a country with the intention of staying and/or becoming a citizen.)

3. Migrant: Yes ◯
No ◯

(A migrant is a person that moves around from place to place.)

4. Initial Primary Nighttime Residence (please check):
- ☐ Not identified as a homeless child or youth
- ☐ Unsheltered
- ☐ Shelters
- ☐ Doubled-up
- ☐ Hotels/Motels

5. Foster Care (please check):
- ☐ No, student has not been placed in foster care.
- ☐ Yes, student has been placed in foster care.

Pulaski County Public Schools

Parental Consent Form

STUDENT INFORMATION

Student Name:

School:

Teacher/ Homeroom Teacher:

In an effort to promote our students accomplishments, Pulaski County Public Schools would like to produce publications for viewing by the general public. These publications include, but are not limited to video productions, internet publications, and written media items.

Our students have made great strides in their scholastic achievements as well as sporting competitions and deserve community recognition of these undertakings.

A parental consent form must be on file for your child before he/she may be photographed. Children may be photographed alone or in a group setting and from varying distances. By signing below, you are authorizing Pulaski County Public Schools to include your child's image in a newspaper article, video production, or internet publication, such as the school's website. Please note written consent does not guarantee inclusion in the publications.

Participation in these publications is purely voluntary and has no bearing on the education of your child. Pulaski County Public Schools respects the wishes of parents and legal guardians and will not produce any documentation that may be damaging to your child's achievement.

It is requested that you sign the form below in one of the corresponding areas.

APPROVAL

My signature below authorizes Pulaski County Public Schools to include my child in a video production, internet publication, or written news item. I have read and understand the conditions of this parental consent form, and I am in agreement with the terms. Furthermore, I hold Pulaski County Public Schools harmless should issues arise resulting from my child's inclusion in these publications.

○ I agree to the above terms and grant permission for my child to be identified by name.

○ I agree to the above terms and do **NOT** grant permission for my child to be identified by name.

_____ _____

Parent's Signature Date

DENIAL

My signature below certifies that I do NOT want my child included in a video production, internet publication or written news item.

_____ _____

Parent's Signature Date

Pulaski County Public Schools
202 North Washington Avenue, Pulaski, VA 24301
Voice: 540-643-0200 | Fax: 540-643-0437

Reach Each Child

Pulaski County Public Schools

202 N. Washington Ave., Pulaski, Virginia 24301

School Name _____

Please complete both parts of this questionnaire by checking the appropriate box concerning your child's race/ethnicity

Student's Name:_____ Date of Birth:____/____/____

Part A. Ethnicity Designation

Is this student Hispanic/Latino? *(Choose one answer)*

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

◯ Yes ◯ No

The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your student's race to be.

Part B. Race Designation

What is the student's race? *(Choose one or more)*

☐ **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, the Middle East, or North Africa.

I verify the information on this questionnaire is accurate.

_____ ____/____/____
Signature, Parent/Guardian *Date*

I refuse to re-identify the race and ethnicity of this student.

_____ ____/____/____
Signature, Parent/Guardian *Date*

FOR SCHOOL USE ONLY

I am the observer who completed this questionnaire due to the parent/guardian refusal to re-identify.

_____ ____/____/____
Signature, Observer *Date*

2) The following circumstances are true of this student's current status:

Currently under suspension or expulsion from another school

YES ○ NO ○

Has ever been suspended or expelled from any school, anywhere, for infractions or violations involving weapons, drugs, alcohol, violence against any student or staff member, vandalism, or destruction of property

Note: ***if the answer to either of the above is "YES", attach a full explanation***

3) I give my permission for the school to request and receive any and all pertinent records of this student's educational progress and history to-date, including (but not limited to) cumulative records, progress reports, IEPs and related documents, 504 plans and related documents, results of medical and/or psychological testing, juvenile justice records, and disciplinary records.

I have read the stipulations on this page and I give my affirmation that all information supplied herein is true and accurate to the best of my knowledge. I further agree to be bound by the laws and policies regulating the operations of the Pulaski County Schools and to uphold the authority of its duly employed professionals and staff members to supervise and direct the activities of this student under my care while enrolled.

Parent/Guardian Date Parent/Guardian Date

Medical or handicapping conditions, known allergies, or other circumstances requiring special handling or treatment: _____

_____

Student is on the following medications: _____

_____

Student's doctor: _____ Phone: _____

In the event of emergency, every effort will be made to contact the parent(s) or guardian(s) immediately. Failing contact, we will contact the emergency contact persons listed above, in order, until someone is notified. If the student is seriously ill or injured, however, and requires absolute immediate medical attention, please indicate your choice of local hospital emergency room:

_____

Parental Certification and Attestation

In signing this page where indicated below, I, as parent or legal guardian of the enrolling student named herein, do attest to and affirm the following:

1) I have provided the school with the following items and information
(School enrollment official initial each below to certify receipt):

☐ This PCS INITIAL STUDENT ENROLLMENT & REGISTRATION Form

☐ Valid certificate of Immunization

☐ Valid certificate of physical examination

☐ Valid, certified birth certificate (school will make a copy and return original)

☐ PCS NONRESIDENT STUDENT APPLICATION (for students whose legal domicile is inside a neighboring division to Pulaski County only)

☐ Most recent report card from the school last attended (for students who have been enrolled in any other school, anywhere, prior to this initial PCS enrollment)

(Non-English speaker) ☐

Transportation Information

Directions to student's home: _____

_____

Student will be brought to school:

☐ By school bus

☐ By private car

☐ On foot or bicycle

Student will be taken home:

☐ By school bus

☐ By private car

☐ On foot or bicycle

As parent(s) or legal guardian(s), I give my permission for this student to be picked up at School by the following designated adults or older siblings (other than parents/guardians) ***ONLY***:

_____

_____

Emergency/ Notification Information

Father/ Stepfather/ Male Guardian: Place of Employment, address, phone contact:

_____

Mother/ Stepmother/ Female Guardian: Place of Employment, address, phone contact:

_____

Secondary Emergency Contacts if required:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Names of Siblings at Home	Age	School Attending	Grade

Previous Enrollment Information (if applicable)

School last attended _____

School address _____

Phone _____

Highest grade completed _____ Withdrawal Date _____

Reason for withdrawal _____

Reason for entering school in Pulaski County _____

_____

Check ALL THAT APPLY to this student:

☐ Served with IEP

☐ Served with 504 plan

☐ Under suspension or expulsion

☐ Served by ESL program

☐ Identified TAG (Talented & Gifted)

☐ Enrolled in remedial reading classes

☐ Enrolled in remedial math classes

☐ Missed more than 10 days last year

Board Policy JEC-E1
Pulaski County Schools

INITIAL STUDENT ENROLLMENT & REGISTRATION FORM

Initial Enrollment for the following student in school year 20 _____- 20___

Student and Family Information

Student's Full Name: _____

Name by which Student prefers to be called: _____

Age _____ Sex _____ Grade _ _____

Birthday _____ Preferred Ethnic Designation _____

Student lives with (check one):

☐ Mother only ☐ Mother and Stepfather

☐ Father only ☐ Father and Stepmother

☐ Both parents ☐ Legal Guardian(s)

Names of parents, stepparents, or legal guardian adults the student lives with:

Mother, stepmother, or female guardian: _____

Father, stepfather, or male guardian: _____

Physical (911) Street Address of the Student's home (no PO Box or rural route only)

_____

Phone _____

Mailing address, if different from physical address:

_____

Pulaski County Preschool Application

New River Community Action, Inc
Head Start Program
Pulaski Head Start
1520 Bobwhite Blvd. Pulaski
540.994.5740
Early Learning Center at NRCC
5251 College Drive, Dublin

Kindergarten Attendance Area:
Critzer ◯ Riverlawn ◯
Dublin ◯ Snowville ◉
Pulaski ◯

Verification of Birth ◯ Yes ◉ No

Pulaski Co. Public Schools
Virginia Preschool Initiative
202 N. Washington Ave.
Pulaski, VA 24301
540.994.2548

Child's Information

Child's Full Name: (First) (Middle) (Last) _____ Date of Birth: _____ ◯ Male ◉ Female

Physical Address: _____

Mailing Address (if different from physical): _____

Directions to the home. *Please include route numbers and significant landmarks.* _____

Please list current and past Pre-School/ child care programs your child has attended: _____

Have you applied to another preschool program for 2021 – 2022? (Yes)_____ (No) _____

Parent/Guardian: Information
(List Relationship)

Name: _____ Date of Birth: _____ Lives with child: ◯ Yes ◯ No

Employer: _____ Work #: _____ Total Hours/Week: _____

Home Phone Number: _____ Message/Cell Phone Number: _____ Email address: _____

Parent/Guardian: Information
(List Relationship)

Name: _____ Date of Birth: _____ Lives with child: ◯ Yes ◯ No

Employer: _____ Work #: _____ Total Hours/Week: _____

Home Phone Number: _____ Message/Cell Phone Number: _____ E-mail address: _____

Others in Household (including all siblings)

(Name) ***(Relationship to Child)*** ***(Date of Birth)***

_____

_____

_____

Does Your Child Have Insurance? Yes ◯ No ◯ Please check all types of insurance that apply:

☐ Private Medical Insurance ☐ ☐ Private Dental Insurance ☐ ☐ Medicaid ☐

Date of child's last physical: _____ Date of child's last dentist visit: _____

Are your child's immunizations (shots) up to date? ◯ Yes ◯ No

Program Selection

Please consider my child for the following program(s). I understand that there are limited spaces available in all programs. The more programs for which my child is considered, the more likely s/he will be found eligible to participate. Please list 1st, 2nd and 3rd choices.

_____ Pulaski County Public Schools Virginia Preschool Initiative (4 years old = full school day – **Transportation provided**)

_____ Pulaski Head Start (full school day serving 3 and 4 year olds - **Transportation is limited**)

_____ Head Start Early Learning Center at New River Community College (full school day, serving 3 and 4 year olds - **No Transportation**)

☐ Yes, Parent is currently enrolled as a student at NRCC

Additional Family Information

1. Does your child have any special needs we should be aware of such as: (please mark all that apply.)
   ☐ Developmental Delay ☐ Speech /Language Disorders ☐ ODD, OCD, ADHD ☐ Autism ☐ Traumatic Brain Injury
   ☐ Visual Impairment ☐ Hearing Impairment ☐ Orthopedic impairment or physical limitations
   ☐ Trauma (please explain):_____

2. Does your child receive special education services or related services (have an IFSP or IEP)? ◯ Yes ◯ No (*If yes, staff please obtain Release of Information.)*

3. Does your child have any chronic health conditions or developmental concerns they have seen a specialist and/or prescribed medication?
   ◯ Yes ◯ No If marked yes please list and explain: _____
   _____

4. Child is a Foster Child? ◯ Yes ◯ No

5. Primary Language spoken in household? _____

6. Education/Training: *(Complete only for parent/guardians living with child)*

	Parent /Guardian 1	Parent /Guardian 2
No GED/Diploma (List **last grade attended** in box)		
Has GED/Diploma (please write **GED or Diploma** in box)		
Some College/Associate's Degree/ Other Training (please write **which one** in box)		
Has College Degree (Bachelor's or above) **Please List Degree(s)**		

7. Work/School: *(Please put checkmark in all boxes that apply for each)*

	Parent/Guardian 1	Parent/Guardian 2
Not employed		
Work 20 hours or less/week		
Work 20-30 hours a week		
Work 30+ hours a week		
School (please list number of hours each week in box) **WHERE?**		

8. Do you receive housing assistance? (I.e. rental assistance, no monthly rent or mortgage payment, HUD or other subsidy)? ◯ Yes ◯ No

9. **Transportation: Not available in all locations. Check with individual centers.**
I am available to transport my child to school every day? ◯ Yes ◯ No To a bus stop? ◯ Yes ◯ No

What prevents you from being able to transport your child? _____

Will the bus pick your child up from: ☐ Home ☐ Daycare Center ☐ Baby sitter

If other than your home, **please give address**. _____
Bus Transportation cannot be guaranteed for daycare and babysitters if they are not within the attendance zone.

10. **Your total annual family income: $_____
(Head Start and VPI will need verification of income from the past 12 months**. Application is not complete and cannot be processed without this information.)**

*11. **How did you hear about the program?*** _____

New River Community Action Head Start and the Virginia Preschool Initiative program take into consideration a number of factors in order to determine eligibility. In addition to your income level and the age of your child, number in household, and family needs are noted. Information is voluntary. This information will be considered along with other information shared with our staff during the application process in order to determine eligibility and become familiar with your family.

By signing the application below, I authorize the release of all medical, dental, educational, and developmental information to be shared by New River Community Action Head Start and Pulaski County Public Schools.

_____ _____ _____ _____
Parent /Guardian Signature Date Staff Signature Date

SCHOOL & DAY CARE
MINIMUM IMMUNIZATION REQUIREMENTS

Documentary proof shall be provided of adequate age appropriate immunization with the prescribed number of doses of vaccine indicated below for attendance at a public or private elementary, middle or secondary school, child care center, nursery school, family day care home or developmental center. Vaccines must be administered in accordance with the harmonized schedule of the Centers for Disease Control and Prevention, American Academy of Pediatrics, and American Academy of Family Physicians and must be administered within spacing and age requirements (available at http://www.vdh.virginia.gov/Epidemiology/Immunization/acip.htm). **Children vaccinated in accordance with either the current harmonized schedule or the harmonized catch-up schedules (including meeting all minimum age and interval requirements) are considered to be appropriately immunized for school attendance. (See "Supplemental Guidance for School-required Vaccines" for additional information.)**

Diphtheria, Tetanus, & Pertussis (DTaP, DTP, or Tdap). A minimum of 4 doses. A child must have at least one dose of DTaP or DTP vaccine on or after the fourth birthday. DT (Diphtheria, Tetanus) vaccine is required for children who are medically exempt from the pertussis containing vaccine (DTaP or DTP). Adult Td is required for children 7 years of age and older who do not meet the minimum requirements for tetanus and diphtheria. Effective July 1, 2019, a **booster dose of Tdap vaccine is required for all children entering the 7th grade.**

Haemophilus Influenzae Type b (Hib) Vaccine. This vaccine is required ONLY for children up to 60 months of age. A primary series consists of either 2 or 3 doses (depending on the manufacturer). However, the child's current age and not the number of prior doses received govern the number of doses required. Unvaccinated children between the ages of 15 and 60 months are only required to have one dose of vaccine.

Hepatitis B Vaccine. A complete series of 3 doses of hepatitis B vaccine is required for all children. However, the FDA has approved a 2-dose schedule ***ONLY*** for adolescents 11-15 years of age AND ***ONLY when the Merck Brand* (RECOMBIVAX *HB) Adult Formulation Hepatitis B Vaccine*** is used. If the 2-dose schedule is used for adolescents 11-15 years of age it must be clearly documented on the school form.

Human Papillomavirus Vaccine (HPV). Effective October 1, 2008, a complete series of 3 doses of HPV vaccine is required for females. The first dose shall be administered before the child enters the 6th grade. After reviewing educational materials approved by the Board of Health, the parent or guardian, at the parent's or guardian's sole discretion, may elect for the child not to receive the HPV vaccine.

Measles, Mumps, & Rubella (MMR) Vaccine. A minimum of 2 measles, 2 mumps, and 1 rubella. (Most children receive 2 doses of each because the vaccine usually administered is the combination vaccine MMR). First dose must be administered at age 12 months or older. Second dose of vaccine must be administered prior to entering kindergarten but can be administered at any time after the minimum interval between dose 1 and dose 2.

Pneumococcal (PCV) Vaccine. This vaccine is required ONLY for children less than 60 months of age. One to four doses, dependent on age at first dose, of pneumococcal conjugate vaccine are required.

Polio Vaccine. A minimum of 4 doses of polio vaccine. One dose must be administered on or after the fourth birthday. **See supplemental guidance document for additional information.**

Varicella (Chickenpox) Vaccine. All children born on and after January 1, 1997, shall be required to have one dose of chickenpox vaccine administered at age 12 months or older. Effective March 3, 2010, a second dose must be administered prior to entering kindergarten but can be administered at any time after the minimum interval between dose 1 and dose 2.

For further information, please call the Division of Immunization at 1-800-568-1929 (in state only) or 804-864-8055.

the NRV (540-585-1310) may be able to provide school physicals by appointments only. Some of the local pharmacies and urgent care centers have clinics that will provide school physicals.

- Your child may receive his/her immunizations by your healthcare provider or at the Pulaski (540-440-2188) or Radford City Health Department (540267-8255) by appointment only.
- Please talk with your school nurse or nurse coordinator (643-0531) if you need help getting an appointment for your child's physical.

Your child cannot be admitted to school until the school has on record a copy of a completed comprehensive physical and all the immunization requirements for the state have been met. **We advise parents to bring their child's physical and immunization forms to school when you register for Kindergarten or at least one week before the first day of school. This will give the school nurse time to review the forms and make sure all required information is documented. This will help prevent your child from any delay on the first day of school.**

If your child has any special health care needs, please call to speak to the school nurse. Some health concerns such as Asthma, Seizures, Diabetes, and severe food/insect/latex allergies may require a health care and emergency plan be written for your child at school. Copies of these care plans can be obtained from the school nurse. These care plans need to be completed by the first day of school.

Thank you for your cooperation and we look forward to having your child in Pulaski County Public Schools.

Mary L. Hall, BSN RN
Supervisor of Health Services
Pulaski County Schools
Phone 540 643-0531

Pulaski County Public Schools

Reach Each Child

February 23,2021

To New Kindergarten Parents,

Congratulations, you have a child ready to enroll in Kindergarten. As the School Nurse Coordinator I would like to welcome you and your child to Pulaski County Public Schools. We want it to be a good experience. Our goal is to have all of your child's health records complete so there will be no delay the first day of school.

In your registration packet you will find information concerning the physicals and immunizations required by the State of Virginia and Pulaski County Schools. State law (Code of Virginia 22.1-270) requires that your child is completely immunized and receives a comprehensive physical examination before entering public kindergarten.

- The physical exam must be from a qualified licensed physician, nurse practitioner, or licensed physician assistant. The physical exam must meet the standards prescribed by the State Health Commissioner. The physical exam has to be completed during the twelve months prior to your child's first day of kindergarten.
- Parents need to download and print the Commonwealth of Virginia School Entrance Health Form MCH213G from https://www.vdh.virginia.gov/school-age-health-and-forms/school-health-forms-and-action-plans/
- All the health information on the first page of the Health Form must be completed and signed by a parent/guardian. Your health care provider is responsible for completing pages 2, 3, and 4 of the form. Please note pages 2 and 4 must be signed by your child's health care provider. The health care provider must complete all sections of page 4 before we can accept it at school. (**Please note that while the report of the comprehensive physical examination must contain the elements prescribed by the State Health Commissioner, state law does not require it to be on the School Entrance Health Form, MCH 213G. Report can be on a different form, as long as it is attached to a MCH 213G.)
- Your child can have the physical completed by your healthcare provider, or you may call the Pulaski County Health Department (540-440-2188) to see if they are scheduling appointments for school physicals. The Community Health Center of the NRV (540-585-1310) may be able to provide school physicals by appointments only. Some of the local pharmacies and urgent care centers have clinics that will provide school physicals.
- Your child may receive his/her immunizations by your healthcare provider or at the Pulaski (540-440-2188) or Radford City Health Department (540267-8255) by appointment only. Some of the local pharmacies may provide immunizations.

- Please talk with your school nurse or nurse coordinator (643-0531) if you need help getting an appointment for your child's physical.

Your child cannot be admitted to school until the school has on record a copy of a completed comprehensive physical and all the immunization requirements for the state have been met. **We advise parents to bring their child's physical and immunization forms to school when you register for Kindergarten or at least one week before the first day of school. This will give the school nurse time to review the forms and make sure all required information is documented. This will help prevent your child from any delay on the first day of school.**

If your child has any special health care needs, please call to speak to the school nurse. Some health concerns such as Asthma, Seizures, Diabetes, and severe food/insect/latex allergies may require a health care and emergency plan be written for your child at school. Copies of these care plans can be obtained from the school nurse. These care plans need to be completed by the first day of school.

Thank you for your cooperation and we look forward to having your child in Pulaski County Public Schools.

Mary L. Hall, BSN RN
Supervisor of Health Services
Pulaski County Schools
Phone 540 643-0531

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)			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 (☐ 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_____/_____/_____

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.*):** ___/___/____

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.)

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

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

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

Health Assessment

Date of Assessment: ____/____/_____

Weight:_____lbs. Height:_____ft._____in.

Body Mass Index (BMI):_____BP_____

- ❑ Age / gender appropriate history completed
- ❑ Anticipatory guidance provided

Physical Examination

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

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

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:**_____

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

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

MANCOMUNIDAD DE VIRGINIA

FORMULARIO DE SALUD PARA EL INGRESO ESCOLAR

Formulario de información médica/Informe de examen físico integral/Certificación de vacunación

Parte I – FORMULARIO DE INFORMACIÓN MÉDICA

La ley estatal (Código de Virginia Ref. § 22.1-270) requiere que su hijo esté vacunado y reciba un examen físico integral antes de ingresar al kínder o escuela primaria pública. **El padre/madre o tutor completa esta página (Parte I) del formulario**. El proveedor médico completa la Parte II y la Parte III del formulario. Este formulario debe completarse no más de un año antes del ingreso de su hijo a la escuela.

Nombre de la escuela: _____ Grado actual: _____

Nombre del estudiante: _____
Apellido Nombre Segundo nombre

Fecha nacimiento del estudiante: ____/___/_____ Sexo: _____ Estado o país de nacimiento:_____Idioma principal que habla: _____

Dirección del estudiante_____ Ciudad_____ Estado_____ Código Postal_____

Nombre del padre/madre o tutor legal 1:_____Teléfono:_____-_____-_____Trabajo/celular:_____-_____-_____

Nombre del padre/madre o tutor legal 2:_____Teléfono:_____-_____-_____Trabajo/celular:_____-_____-_____

Contacto de emergencia:_____Teléfono:_____-_____-_____Trabajo/celular:_____-_____-_____

Preferencia de hospital: _____

Seguro médico del niño: Ninguno ☐ FAMIS Plus (Medicaid) ☐ FAMIS ☐ Privado/comercial/patrocinado por el empleador ☐ _____

Cuadro 1. Afecciones preexistentes

Afección	Sí	Comentarios	Afección	Sí	Comentarios
Alergias (alimentos, insectos, medicamentos,látex). Indique **alergias potencialmente mortales**:			Diabetes: Tipo 1		
			Diabetes: Tipo 2		
			Bomba de insulina		
Alergias (estacionales)			Traumatismo craneal, conmoción cerebral		
Asma o afecciones respiratorias			Afecciones auditivas o sordera		
Trastorno por déficit de atención/hiperactividad			Afecciones cardíacas		
Afecciones conductuales/psíquicas/sociales			Intoxicación con plomo		
Afecciones del desarrollo			Afecciones musculares		
Afecciones de la vejiga			Convulsiones		
Afecciones de sangrado			Anemia de células falciformes (no trazas)		
Afecciones intestinales			Afecciones del habla		
Parálisis cerebral			Lesión de la médula espinal		
Fibrosis quística			Cirugía		
Afecciones de la salud dental			Afecciones de la vista		

Describa cualquier otra información importante relacionada con la salud de su hijo (☐ Sonda de alimentación, ☐ Traqueostomía, ☐ Aporte suplementario de oxígeno, ☐ Audífonos, ☐ Aparato dental, Silla de ruedas, Hospitalizaciones, etc.):

Cuadro 2. Medicamentos

Enumere todos los medicamentos recetados, de emergencia, de venta libre y hierbas medicinales que su hijo toma con regularidad (hogar/escuela):

Nombre del medicamento	Dosis	Hora de administración (hogar/escuela)	Notas
1.			
2.			
3.			
4.			

Medicamentos adicionales (nombre, dosis, hora de administración, notas)

Marque aquí si desea discutir información confidencial con la enfermera de la escuela u otra autoridad escolar ☐ Sí ☐ No Proporcione la siguiente información:

	Nombre	Teléfono	Fecha de la última cita
Pediatra/proveedor de atención primaria			
Especialista			
Dentista			
Trabajador del caso (si corresponde)			

Yo_____ (autorizo) (no autorizo) al proveedor de atención de salud de mi hijo y al proveedor de atención de salud designado en el entorno escolar para discutir las preocupaciones de salud de mi hijo o intercambiar información relacionada con este formulario. Esta autorización estará vigente hasta que usted la retire. Puede retirar su autorización en cualquier momento comunicándose con la escuela de su hijo. Cuando se divulga información del expediente de su hijo, la documentación de la divulgación se mantiene en el expediente académico o de salud de su hijo.

Firma del padre/madre o tutor legal:_____Fecha:_____/_____/_____

Firma del intérprete: _____Fecha:_____/_____/_____

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)			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 (☐ 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_____/_____/_____

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.*):** ___/___/____

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.)

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

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

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

Health Assessment

Date of Assessment: ____/____/_____

Weight:_____lbs. Height:_____ft._____in.

Body Mass Index (BMI):_____BP_____

❑ Age / gender appropriate history completed

❑ Anticipatory guidance provided

Physical Examination

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

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

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::_____

____I**ndividualized 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:**_____