2017-2018 Kindergarten Registration

Glenkirk Elementary’s Kindergarten Registration for the 2017-2018 school year will be held at Glenkirk Elementary on Thursday, April 6th from 9:30am – 2:30pm and Thursday, April 20th from 1:00pm – 7:00pm, no appointments are necessary. We would like to perform an assessment of kindergarten readiness skills on your child, so please make sure to bring your child with you at that time.

Students who will be five years of age or older by September 30, 2017 are eligible for enrollment in kindergarten for the 2017-2018 school year. Registration will take place in our school gym for the students who reside within Glenkirk Elementary school boundaries. If you are not sure of the school your child should attend during the 2017-2018 school year, you can call the School Planning Office at 703-791-7312 or go to www.pwcs.edu and click on Parents, then Find Your School.

A certified copy of the child’s birth certificate is required at the time of registration, along with three proofs of residence (one must be a copy of the deed, rental or lease agreement, or a notarized Affidavit of Residency attesting to bona fide residency in Prince William County), a valid immunization record signed by a healthcare professional, and a comprehensive physical exam dated within twelve months of the child’s entry into the public school system. All original documents will be returned to the parent.

The immunization record must document four doses of DTaP with one dose received after the fourth birthday; four doses of a polio vaccine with one dose received after the fourth birthday; two doses of the measles vaccine with first dose received at 12 months of age or older (usually given as MMR); two doses of mumps vaccine received at 12 months of age or older (usually given as MMR); one dose of a rubella vaccine received at 12 months of age or older (usually given as MMR) second dose of MMR given after 4th birthday; three doses of hepatitis B vaccine; *Effective March 3, 2010 all kindergarten students must have 2 doses of varicella (chicken pox) vaccine: first dose at 12 months or older AND a second dose administered no earlier than three months from the first dose (the second dose is usually administered after the fourth birthday).
**Prince William County Public Schools Registration Form**

### STUDENT INFORMATION

(Please print)  
Please complete all blanks except shaded areas

<table>
<thead>
<tr>
<th>Legal Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Grade</th>
<th>Gender</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>House Type</th>
<th>Street Number</th>
<th>Street Name (also designate Court, Drive, Lane, etc.)</th>
<th>(Apt#)</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

Mailing Address (if different from above)

<table>
<thead>
<tr>
<th>Prince William County Public Schools last attended, if applicable</th>
<th>Virginia Public School last attended (if not in Prince William Co.)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Student’s Birth Date</th>
<th>Birthplace (city, state/country)</th>
<th>Birth Certificate Number</th>
<th>Please circle yes or no</th>
</tr>
</thead>
</table>

**Ethnicity – Please circle yes or no**

<table>
<thead>
<tr>
<th>Hispanic or Latino</th>
<th>Race: Please circle all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y / N</td>
<td>1. American Indian or Alaska Native</td>
</tr>
<tr>
<td></td>
<td>2. Asian</td>
</tr>
<tr>
<td></td>
<td>3. Black or African American</td>
</tr>
<tr>
<td></td>
<td>4. Native Hawaiian or other Pacific Islander</td>
</tr>
<tr>
<td></td>
<td>5. White</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Most Recent School Attended</th>
<th>City, State</th>
</tr>
</thead>
</table>

**PARENT/GUARDIAN INFORMATION**

**PLEASE COMPLETE ALL APPLICABLE INFORMATION USING N/A WHEN NECESSARY**

<table>
<thead>
<tr>
<th>Father’s Full Name</th>
<th><em>Military Connected</em></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

- Parent  
- Stepparent  
- Legal Guardian  
- Foster Parent  

(check as applicable)

<table>
<thead>
<tr>
<th>Street Number</th>
<th>Street Name (also designate Court, Drive, Lane, etc.)</th>
<th>(Apt#)</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

10-digit Home Phone # | Employed by | 10-digit Work Phone # | Ext. | Cell phone |

<table>
<thead>
<tr>
<th>Work Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>E-Mail Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Mother’s Full Name</th>
<th><em>Military Connected</em></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

- Parent  
- Stepparent  
- Legal Guardian  
- Foster Parent  

(check as applicable)

<table>
<thead>
<tr>
<th>Street Number</th>
<th>Street Name (also designate Court, Drive, Lane, etc.)</th>
<th>(Apt#)</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

10-digit Home Phone # | Employed by | 10-digit Work Phone # | Ext. | Cell phone |

<table>
<thead>
<tr>
<th>Work Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>E-Mail Address</th>
</tr>
</thead>
</table>

**Verification of Residency in School Attendance Area:**

- Deed or Contract
- Lease
- Affidavit
- Other Documentation

Foster Child  
Yes  
No  
In-State  
Out-of-State  
Give County and State of Foster Child

If Tuition Student, is Tuition Paid by Parent  
Yes  
No  
In-State  
Out-of-State  
Tuition Code

Medicaid Eligible  
Yes  
No

Parent or Guardian Signature____________________________________________________  
Date___________________________

Rev. 8/15
CONSENT FOR RELEASE OF INFORMATION

Please print

Full Name of Student __________________________________________

Date of Birth ________________________________________________

I hereby authorize:

Previous School _____________________________________________

Address _____________________________________________________

________________________________________________________________

________________________________________________________________

to release all educational records concerning my child including:

  ___ an up-to-date transcript and/or report card
  ___ grading scale
  ___ test scores
  ___ discipline records
  ___ health and attendance records
  ___ I.E.P., if applicable
  ___ psychological and social history information, if applicable

To:        Current School _________________________________________

Address _____________________________________________________

________________________________________________________________

________________________________________________________________

Signature of Parent or Guardian _______________________________ Date ____________________

Street Address ______________________________________________ Daytime Telephone ____________________

City __________________ State ______ Zip ____________________________

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

Part I – HEALTH INFORMATION FORM

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

Name of School: ____________________________________________________________________________________

Current Grade: ____________________

Student’s Name: ________________ _____________________________________________________________________________________________________________

Last Name: ____________

First Name: __________________________

Middle Name: __________________________

Student’s Date of Birth: _____/_____/_______

Sex: _______

State or Country of Birth: ________________________

Main Language Spoken: ______________

Student’s Address: ______________________________________________________

City: ____________________

State: _______________

Zip: _______________

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: _____-_____-______

Condition | Yes | Comments | Condition | Yes | Comments
--- | --- | --- | --- | --- | ---
Allergies (food, insects, drugs, latex) |  |  | Diabetes |  |  |
Allergies (seasonal) |  |  | Head injury, concussions |  |  |
Asthma or breathing problems |  |  | Hearing problems or deafness |  |  |
Attention-Deficit/Hyperactivity Disorder |  |  | Heart problems |  |  |
Behavioral problems |  |  | Lead poisoning |  |  |
Developmental problems |  |  | Muscle problems |  |  |
Bladder problem |  |  | Seizures |  |  |
Bleeding problem |  |  | Sickle Cell Disease (not trait) |  |  |
Bowel problem |  |  | Speech problems |  |  |
Cerebral Palsy |  |  | Spinal injury |  |  |
Cystic fibrosis |  |  | Surgery |  |  |
Dental problems |  |  | Vision problems |  |  |

Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.):
________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________

List all prescription, over-the-counter, and herbal medications your child takes regularly:

________________________________________________________________________________________________________________________________________________

Check here if you want to discuss confidential information with the school nurse or other school authority.  □ Yes  □ No

Please provide the following information:

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
<th>Date of Last Appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatrician/primary care provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Worker (if applicable)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Child’s Health Insurance:  ____ None  ____ FAMIS Plus (Medicaid)  ____ FAMIS  ____ Private/Commercial/Employer sponsored

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

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

Signature of person completing this form: __________________________________________________________________________ Date: _____/_____/

Signature of Interpreter: __________________________________________________________________________ Date: _____/_____/

MCH 213G reviewed 03/2014
COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

Section I
To be completed by a physician or his designee, registered nurse, or health department official.
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. Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

<table>
<thead>
<tr>
<th>IMMUNIZATION</th>
<th>RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Diphtheria, Tetanus, Pertussis (DTP, DTaP)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>*Tdap booster (6th grade entry)</td>
<td>1</td>
</tr>
<tr>
<td>*Polioyelitis (IPV, OPV)</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>*Haemophilus influenzae Type b (Hib conjugate) *only for children &lt;60 months of age</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>*Pneumococcal (PCV conjugate) *only for children &lt;60 months of age</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella (MMR vaccine)</td>
<td>1 2</td>
</tr>
<tr>
<td>*Measles (Rubeola)</td>
<td>1 2 Serological Confirmation of Measles Immunity:</td>
</tr>
<tr>
<td>*Rubella</td>
<td>1 Serological Confirmation of Rubella Immunity:</td>
</tr>
<tr>
<td>*Mumps</td>
<td>1 2</td>
</tr>
<tr>
<td>*Hepatitis B Vaccine (HBV)</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Merck adult formulation used</td>
<td></td>
</tr>
<tr>
<td>*Varicella Vaccine</td>
<td>1 2 Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:</td>
</tr>
<tr>
<td>Hepatitis A Vaccine</td>
<td>1 2</td>
</tr>
<tr>
<td>Meningococcal Vaccine</td>
<td>1</td>
</tr>
<tr>
<td>Human Papillomavirus Vaccine</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Other</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Other</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

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.): ___/___/____

MCH 213G reviewed 03/2014
Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date.

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/Td: [ ]; OPV/IPV: [ ]; Hib: [ ]; Pneum: [ ]; Measles: [ ]; Rubella: [ ]; Mumps: [ ]; HBV: [ ]; Varicella: [ ]

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-I), 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.)

Certification of Immunization 03/2014
### COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no later 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](http://www.vahealth.org/schoolhealth).

#### Student’s Name: ________________________________

#### Date of Birth: _____/_____/______  Sex: □ M  □ F

#### Date of Assessment: _____/_____/______

<table>
<thead>
<tr>
<th>Weight: ______ lbs.  Height: ______ ft.  ______ in.</th>
</tr>
</thead>
</table>

#### Health Assessment

- Body Mass Index (BMI): ______
- Age / gender appropriate history completed
- Anticipatory guidance provided
- TB Screening: □ 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: ______
- CXR Date: ______
- EPSDT Screens: Required for Head Start – include specific results and date:
  - Blood Lead: __________________________________________
  - Hct/Hgb: __________________________________________
- TB Screening: □ 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: ______
- CXR Date: ______
- EPSDT Screens: Required for Head Start – include specific results and date:
  - Blood Lead: __________________________________________
  - Hct/Hgb: __________________________________________

#### Physical Examination

<table>
<thead>
<tr>
<th>1 = Within normal  2 = Abnormal finding  3 = Referred for evaluation or treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  2  3  1  2  3  1  2  3</td>
</tr>
</tbody>
</table>

HEENT  □  □  □  Neurological  □  □  □  Skin  □  □  □
Lungs  □  □  □  Abdomen  □  □  □  Genital  □  □  □
Heart  □  □  □  Extremities  □  □  □  Urinary  □  □  □

#### Developmental Screen

- Assessed for:
  - Educational/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:
  - 1000  2000  4000
  - R
  - L
  - □ Screened by OAE (Otoacoustic Emissions): □ Pass  □ Refer

#### 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

- □  Problem Identified: Referred for treatment
- □  No Problem: Referred for prevention
- □  No Referral: Already receiving dental care

#### Summary of Findings (check one):

- □ All 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 autoinjector  □ 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: __________________________________

#### Recommendations to (Pre) School, Child Care, or Early Intervention Personnel

- □ Preventive care needed
- □ Medical care needed
- □ Transportation needed
- □ Occupational therapy needed
- □ Physical therapy needed
- □ Speech therapy needed
- □ Psychological services needed
- □ Social Work services needed
- □ Other services needed

#### Other Comments:

- □ Preventive care needed
- □ Medical care needed
- □ Transportation needed
- □ Occupational therapy needed
- □ Physical therapy needed
- □ Speech therapy needed
- □ Psychological services needed
- □ Social Work services needed
- □ Other services needed

#### Health Care Professional’s Certification

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: __________________________  Date: _____/_____/______

Practice/Clinic Name: __________________________  Address: __________________________

Phone: - - - -  Fax: - - - -  Email: __________________________
PRINCE WILLIAM COUNTY PUBLIC SCHOOLS
DISCLOSURE OF CHILD’S DISCIPLINARY AND CRIMINAL HISTORY PRIOR TO ENROLLMENT

Dear Parent or Guardian:

Under Virginia law and School Board regulation, you must provide the information requested below. You must disclose whether the child you are enrolling has ever been expelled, long-term suspended, or withdrawn from any school or placed in an alternative education program for disciplinary reasons, including an expulsion or long-term suspension which is pending at the time the student moves from another school or district. You must disclose this information regardless of whether it occurred in a public or private school location. The Virginia Code also requires disclosure of information concerning convictions or delinquency adjudications for criminal offenses including, but not limited to, those offenses listed on the reverse side of this document. Prince William County Public Schools also requires disclosure of charges for criminal offenses listed on the reverse side of this document.

You must complete this form before your child may be registered. The School Division will keep this document confidential as part of your child’s scholastic record. IF YOU MAKE A FALSE STATEMENT ON THIS FORM, YOU MAY BE GUILTY OF A CLASS 3 MISDEMEANOR. A school employee will witness your signature.

Student’s Name: ____________________________________________

1. Has the child you are enrolling ever been suspended for more than five days for a single infraction? □ Yes □ No

2. Is there disciplinary action pending against the child you are enrolling in the previous school district? □ Yes □ No
   What was/were the offense(s) which resulted in the child you are enrolling being suspended for the above?
   __________________________________________________________
   __________________________________________________________

3. Has the child you are enrolling ever been placed on long-term suspension (10 or more consecutive days)? □ Yes □ No
   If yes, for how long? _______________________________________

4. Has the child you are enrolling ever been expelled? □ Yes □ No
   If yes, for what infraction? ________________________________
   __________________________________________________________
   __________________________________________________________

5. Has the child you are enrolling ever been referred to or attended an alternative education program? □ Yes □ No
   If yes, name, address, and telephone number of program: ________________________________
   __________________________________________________________
   __________________________________________________________

6. Has the child you are enrolling ever been withdrawn from any school for disciplinary reasons? □ Yes □ No
   If yes, for what reason? _____________________________________
   __________________________________________________________
   __________________________________________________________

7. Has this child been charged or adjudicated delinquent for any criminal or other offense? □ Yes □ No
   If yes, what was the offense and what resulting consequences were imposed by the judicial system?
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

Parent/Guardian Signature: ___________________________ Date: __________________________

Witness: ________________________________________________

(PLEASE REVIEW REVERSE SIDE OF THIS DOCUMENT)
STUDENT'S NAME ___________________ SCHOOL ___________________

Dear Parent/Guardian:

Prince William County Public Schools regulations require that enrolling students, who have spent at least three consecutive months outside of the United States and U.S. territories (Puerto Rico, Guam, U.S. Virgin Islands, American Samoa and the Northern Mariana Islands) during the previous five years, submit proof of tuberculosis screening at the time of enrollment.

Such students are required to present documentary evidence as follows:

A. A written report of a negative PPD test (Mantoux method) administered within 30 calendar days prior to school registration or written report from a health care provider stating that the student is cleared to start school, as deemed appropriate for the results of screening. This written report must be certified by the Department of Health, a physician, or a nurse practitioner licensed to practice medicine in the United States.

or

B. A clearance letter from the Prince William Health District (PWHD) or licensed health care provider stating that the student is free of communicable tuberculosis (see Attachment II).

or

C. A medical exemption to the testing requirement issued by a licensed physician or nurse practitioner, or a local health department in Virginia. If the exemption is temporary, the exemption document must indicate the conditions of the exemption and the date the exemption expires. A TB symptom assessment shall be done (see Attachment III). If the TB symptom assessment is positive, the student shall have a chest x-ray and evaluation for active disease before school entry.

Please check the statement below which applies to the enrolling student:

__________ The enrolling student has not resided outside the United States for three consecutive months in the past five years.

__________ The enrolling student has resided outside the United States for at least three consecutive months within the past five years and I understand that I must present evidence of tuberculin screening as described in this document.

Students will not be permitted to enter school without written documentation as requested.

______________________________  ___________________________
Parent/Guardian Signature       Date
Dear Licensed Health Care Provider:

Please provide the following information for:

Name of Student: __________________________________________________________

I certify that the above named student has had a chest x-ray and _____ is/____ is not free from communicable tuberculosis.

Name of Licensed Physician or Nurse Practitioner: ________________________________

Address: __________________________________________________________________

Phone: __________________________________________________________________

________________________________________________________________________

Signature ___________________________ Date ___________________________
Tuberculosis Symptom Assessment

- Cough for more than three weeks
- Unexplained fever
- Coughs up blood
- Unexplained weight loss
- Unexplained chest pain
- Night sweats
- Poor appetite
- FOR CHILDREN UNDER SIX YEARS OLD
  - Wheezing
  - Failure to thrive
  - Decreased activity and/or energy
  - Lymph node swelling
  - Personality changes

Comments

Parent Signature   School Nurse's Signature

Date             Date

If student presents with one or more of the above symptoms, refer to their health care provider for further evaluations prior to school entry.
**Home Language Survey (HLS)**

**Directions for Parent / Guardian:** Please enter a complete and accurate response for each number 1 through 11, using Not Applicable (N/A) when needed. If you have a question, please contact a staff member, who will be happy to help.

PWCS offers free language support. Say your language, or point to the Language Assistance Poster.

**Student’s Name (First, Last):** ____________________________  Date of Birth: ____________________________

For questions 1-5, write all applicable languages:

1. **What was the first language your child spoke?**
2. **What language, other than English, does your child speak?**
3. **What language, other than English, does your child understand?**
4. **What language, other than English, is routinely used in the home?**
5. **In which languages do you prefer to receive communication from the school?**
   - Please respond for both verbal and written: Verbal: English or other ______ (please specify)
   - Written: English or other ______ (please specify)

6. **Country of Birth**
   - (same as entered on Registration Form)

7. **Original Date of Entry into the U.S.A.**
   - (if born outside the U.S.A.)

8. **Date of Most Recent Entry into U.S.A.**
   - (if applicable)

9. **Did the student attend schools in the U.S. previously?** Yes / No
   - If Yes, Date of original Entry into U.S. Schools ____________________________
   - If No, Registrar will enter expected first date of attendance in PWCS __________

10. **Did the student attend public schools in Virginia previously?** Yes / No
    - If Yes, Original Date of Entry into Virginia public schools K-12 ____________________________
    - If No, Registrar enters expected first date of attendance in PWCS ____________________________

11. **List ALL Schools Previously Attended**

<table>
<thead>
<tr>
<th>School</th>
<th>Country / State</th>
<th>Grade Level</th>
<th>Dates (Start/End)</th>
<th>School Records Provided Yes/No</th>
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</table>

Name of parent/guardian who completed the form ____________________________  Relationship to Student ____________________________

Parent/guardian signature: ____________________________  Date: ____________________________

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**Federal regulations require school systems to survey every student at the time of enrollment regarding the student’s home language and other languages the student may speak and/or understand. This form meets requirements of the Equal Educational Opportunity Act 20 USC 1703 for identification of national origin minority children. Based on this survey, a student may be assessed, as required by federal regulations, for English language proficiency.**

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**OFFICIAL USE ONLY: TO BE COMPLETED BY OFFICE STAFF** (please print)

Form reviewed for completion and accuracy by:

PWCS staff member ____________________________  Title ____________________________  Date: ____________________________  School/Office ____________________________

Home Language Survey forms are available at pwcs.edu, within the Translations Library. Circle the language provided to the family:

- English, Spanish, Urdu, Arabic, Vietnamese, Farsi, Korean, Bengali, Amharic, French, Tagalog, Mandarin Chinese, Nepali

Print Name of Person or Company providing interpretation services: ____________________________  Specify Language: ____________________________

Routing: School Registrar Instructions

- If a language other than English is indicated in questions 1, 2, or 3 provide a copy of the Home Language Survey and Base School Verification Form to Central Registration Services Immediately.
- Sent to CRS at Ann Ludwig or Stonewall Middle (circle one)
- Date Sent to Central Registration Services ____________________________

Routing: Central Registration Services (CRS) Instructions

- Date Received by CRS ____________________________  Initials ____________________________
- Date sent to Dept. Chair / Lead Teacher ____________________________

**Home Language Identified in SMS**

- Dates updated in SMS ____________________________

- Updated HLS sent to Registrar for placement in File #1 and File #6 (used in cases when CRS does not have the original files)

**Note:** If school registrar completes the home language fields in SMS, please use guidance provided in PowerSchool SMS Training and Enrollment Manual.
This form is used to determine what preschool services your child was enrolled in during the year prior to kindergarten: Please tell us what type of preschool program your child attended and the number of hours per week they attended per week.

Child’s Name _________________________________

Circle the option that best describes what preschool services your child was enrolled in.

1 – Community based Head Start (NOT in a public school)
2 - Public Preschool (attended Head Start, VPI, VPI+, Speech Services, or Preschool Special Education in a public school)
3 - Private Preschool/ Day Care
4 - Department of Defense Child Development Program
5 - Family Home Daycare Provider
6 - Child did not attend preschool

Put an X next to the number of hours per week your child attended a preschool program:

_____ Child did not attend preschool
_____ Less than 15 hours per week
_____ Between 15 and 29 hours per week
_____ 30 or more hours per week