

STUDENT ENROLLMENT INFORMATION

Student's Full Name			
LAST:	FIRST:	MIDDLE:	SUFFIX:

Grade Level	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	① First language the student acquired	② Language most often spoken by the student
Nickname		③ Primary language spoken in the home, regardless of the language spoken by the student	
Student's Birthdate		④ Does the student speak any language other than English? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, what language(s)?	
Birth Certificate No.		⑤ Was the student in an ESL (also called ELL/LIEP/ESOL/ENL) program in another school? <input type="checkbox"/> No <input type="checkbox"/> YES - SCHOOL _____ HOW LONG? _____	
Student's Birth City and State OR Country CITY: STATE: COUNTRY:			When did student first enter United States schools? DATE:
Is student of Hispanic or Latino descent? <input type="checkbox"/> YES <input type="checkbox"/> NO A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race.			
What race code or combination of codes best describes student's background? Please check ALL that apply. More than one code is acceptable			
<input type="checkbox"/> American Indian or Alaskan Native		<input type="checkbox"/> Asian	<input type="checkbox"/> White
<input type="checkbox"/> Black or African American		<input type="checkbox"/> Native Hawaiian or Pacific Islander	

Student's Address ZIP CODE:	Home Telephone No.
Resident of: <input type="checkbox"/> Roanoke County <input type="checkbox"/> Vinton <input type="checkbox"/> Other _____	

<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/> Stepfather <input type="checkbox"/> Stepmother NAME: Address <input type="checkbox"/> Same as Student ZIP CODE:	Home Telephone No. Cell Phone No. E-mail address Business Telephone ext
<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/> Stepfather <input type="checkbox"/> Stepmother NAME: Address <input type="checkbox"/> Same as Student ZIP CODE:	Home Telephone No. Cell Phone No. E-mail address Business Telephone ext

Student lives with: (check all that apply)

☐ Both parents
 ☐ Father
 ☐ Mother
 ☐ Stepfather
 ☐ Stepmother
 ☐ Grandparents
 ☐ Foster Home
 ☐ Foster Parent
 ☐ Family & Children's Services
 ☐ Other _____

Verification of legal guardianship (court order) Copy required at enrollment in RCPS ☐

*Please provide name and school of all siblings (include half, step) attending a Roanoke County school.

Complete Name	Age	School	Complete Name	Age	School

Date entered public school for the first time	Has student attended preschool or day care? <input type="checkbox"/> YES <input type="checkbox"/> No If so, where? _____
Date entered current school	Has student ever repeated a grade? <input type="checkbox"/> YES <input type="checkbox"/> No If so, what grade? _____
Has student ever attended a Roanoke County school? <input type="checkbox"/> YES <input type="checkbox"/> No If so, what grade? _____ when? _____ where? _____	
Has student ever received services from a Roanoke County school? (i.e speech, OT, etc.) <input type="checkbox"/> YES <input type="checkbox"/> No If so, what grade? _____ when? _____ where? _____	
Has student participated in any of the following programs? <input type="checkbox"/> Gifted <input type="checkbox"/> Title 1 <input type="checkbox"/> Special Education <input type="checkbox"/> English Sec. Lang <input type="checkbox"/> Other _____	

List all schools attended by student (in order):

<u>Complete Name of School</u>	<u>City, State</u>	<u>Grade Levels</u>	<u>Years Attended</u>
(1)			
(2)			
(3)			
(4)			
(5)			

Any physical, emotional, or special health problems, such as allergies, which the school should be aware of? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Does student have any known allergies or phobias to dogs? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Name of family doctor	Telephone No.
Do you give the school permission to call the doctor or send the child to the hospital in the event you cannot be located? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Do you assume responsibility for the cost? <input type="checkbox"/> YES <input type="checkbox"/> NO	

I confirm that I have legal custody of this student and that the information is accurate to the best of my knowledge.

Parent's Signature

Date

The Code of Va.(§ 22.1-264.1) makes it a misdemeanor to knowingly give false information to schools regarding residence for the purpose of enrolling a child in a school outside their legal attendance area.

The Code of Va (§ 22.1-260) requires that each student present a social security number within ninety days of enrollment. This is used for student verification. The 1986 Federal Tax Act requires that no student be excluded from school for failure to provide a social security number.

RESIDENCY VALIDATION**Enrollment and Change of Address**

Roanoke County Public Schools requires all schools to document proof of residency for each student enrolled. As a result, each time a student is being registered or requesting a change of address in Roanoke County Public Schools, it is necessary that the parent or guardian present reasonable proof of residing in our school district. It is understood that deliberate falsification or providing misleading information for school attendance purposes in a Roanoke County Public School will result in your child being immediately withdrawn from the Roanoke County Public Schools.

Please select one:

☐ **My family resides with another Roanoke County homeowner.**

If your family resides with another homeowner, please complete **ONLY** the information on the other side of this page. The homeowner you reside with will need to be present to provide identification and signature to complete. In addition, form AD.5-108A must be completed by homeowner and notarized.

☐ **My family does not reside with another Roanoke County homeowner.**

If your family is the primary homeowner, please complete **ONLY** the information requested below.

Residency documentation:

Please provide documentation of residency. Acceptable documentation includes:

- Mortgage documentation or Deed
- Current lease
- Current real estate tax statement

All Residency documentation needs to be of your principal residence in Roanoke County

Va. legal code makes it a class 4 misdemeanor for any person to knowingly make a false statement concerning the residency of a child in a particular school division or school attendance zone for the purpose of avoiding tuition charges or enrollment in a school outside the attendance zone in which the student resides.

I, _____ (Print Parent Name*) am aware of this procedure, which states that if a student is found to have established residency in our attendance area by using false or inaccurate information, the student will be immediately withdrawn from school; according to Virginia High School regulations, the student will lose extracurricular eligibility for 365 days from the date the information is certified as being false (VHSL Regulation 30-5-3.)

Student Name: _____ Grade: _____

Address: _____

*Parent's Signature: _____ Date: _____

Verification documentation presented: _____

Verification documentation copied for student file Date: _____

Verified by: _____ Date: _____

Siblings attending Roanoke County Public Schools? ☐ YES ☐ NO

Complete this section if your family resides with someone else:

Residency documentation:

Please provide documentation of residency. Acceptable documentation includes if you reside with someone else as your principal residence in Roanoke County.

If you reside with someone else and do not have a mortgage, lease, or Roanoke County property tax statement, you must provide the following three (3) documents:

- (a) If you are living with someone, the homeowner you are living with must provide one document from the list below:
 - their mortgage or deed
 - property tax assessment
 - updated lease including all members living in the home
 - proof of home purchase with mortgage within 30-45 days
- (b) Notarized statement provided by the homeowner that you (parent(s) and child) live at the address as your principal residence in Roanoke County.

- (c) Parent to provide current valid document from the list of alternate proof of residency listed below:

Each document must be the original document and show name and address of the residence as it appears on the students/parents enrollment forms. The street address must be shown on all acceptable documents. A post office box or business address is not acceptable.

- Payroll check stub issued by an employer within the last two months.
- Original monthly bank statement not more than two months old issued by a bank
- Utility bill, not more than two months old, issued to parent: examples include: gas, electric, sewer, or cable. Cellular phone bills are not accepted. Utility bills must be submitted in full.

Va. legal code makes it a class 4 misdemeanor for any person to knowingly make a false statement concerning the residency of a child in a particular school division or school attendance zone for the purpose of avoiding tuition charges or enrollment in a school outside the attendance zone in which the student resides.

I, _____ (Print Parent Name*) am aware of this procedure, which states that if a student is found to have established residency in our attendance area by using false or inaccurate information, the student will be immediately withdrawn from school; according to Virginia High School regulations, the student will lose extracurricular eligibility for 365 days from the date the information is certified as being false (VHSL Regulation 30-5-3.) Furthermore, the parents will be required to pay all non-residency fees incurred while the student was enrolled in Roanoke County Public Schools.

Student Name: _____ Grade: _____

Address: _____

*Parent's Signature: _____ Date: _____

Homeowner's Signature: _____ Date: _____
(Homeowner must be present to complete this section, show ID and provide signature with school staff)

Verification documentation presented: _____

Verification documentation copied for student file Date: _____

Verified by: _____ Date: _____

Siblings attending Roanoke County Public Schools? ☐ YES ☐ NO

VERIFICATION OF RESIDENCY

This is to confirm that _____ and his/her
Student Name

Mother/Father/Guardian, _____ reside with me
Name of Mother/Father/ Guardian

full-time at this address: _____

City State Zip

He/she will reside with me full-time until the end of the school year. If there is any change in residency status, I will immediately notify the school.

I understand that if residency is not valid, the student will be required to withdrawn from school and by the Virginia High School regulations the student will lose extracurricular eligibility for 365 days from the date the information is certified as being false (VHSL Regulation 30-5-3). Furthermore, the parents will be required to pay all non-residency fees incurred while the student was enrolled in Roanoke County Public Schools.

Homeowner Name

Homeowner Signature

Relationship to Student

Date

Notary Information

Va. legal code makes it a class 4 misdemeanor for any person to knowingly make a false statement concerning the residency of a child in a particular school division or school attendance zone for the purpose of avoiding tuition charges or enrollment in a school outside the attendance zone in which the student resides.

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:

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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.):

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Signature of Medical Provider or Health Department Official: _____ Date (Mo., Day, Yr.):

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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.):

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Section III Requirements

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

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

Part III – COMPREHENSIVE PHYSICAL EXAMINATION REPORT

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

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

Health Assessment	Date of Assessment: ____/____/____ Weight: _____ lbs. Height: _____ ft. ____ in. Body Mass Index (BMI): _____ BP _____ <input type="checkbox"/> Age / gender appropriate history completed <input type="checkbox"/> Anticipatory guidance provided	Physical Examination 1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment											
	HEENT	1	2	3	Neurological	1	2	3	Skin	1	2	3	
	Lungs				Abdomen				Genital				
	Heart				Extremities				Urinary				
	Tuberculosis Screening Check the box that applies: <input type="checkbox"/> No risk for TB infection identified <input type="checkbox"/> No symptoms compatible with active TB disease <input type="checkbox"/> Risk for TB infection or symptoms identified												
	Test for TB Infection: TST IGRA Date: _____ TST Reading _____ mm TST/IGRA Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive CXR required if positive test for TB infection or TB symptoms. CXR Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal												
	EPSDT Screens <u>Required</u> 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	<input type="checkbox"/> Screened at 20dB: Indicate Pass (P) or Refer (R) in each box. <input type="checkbox"/> Screened by OAE (Otoacoustic Emissions): <input type="checkbox"/> Pass <input type="checkbox"/> Referred		<input type="checkbox"/> Referred to Audiologist/ENT <input type="checkbox"/> Unable to test – needs rescreen <input type="checkbox"/> Permanent Hearing Loss Previously identified: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Hearing aid or another assistive device		

Vision Screen	<input type="checkbox"/> With Corrective Lenses (Check if yes) <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="4">Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not tested</td> </tr> <tr> <td>Distance</td> <td>Both</td> <td>R</td> <td>L</td> </tr> <tr> <td></td> <td>20/</td> <td>20/</td> <td>20/</td> </tr> <tr> <td colspan="4">Test used: _____</td> </tr> </table>	Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not tested				Distance	Both	R	L		20/	20/	20/	Test used: _____				Dental Screen	<input type="checkbox"/> Problems Identified: Referred for Treatment <input type="checkbox"/> No Problem: Referred for prevention <input type="checkbox"/> No Referral: Already receiving dental care <input type="checkbox"/> Unable to perform
	Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not tested																		
	Distance	Both	R	L															
		20/	20/	20/															
Test used: _____																			

Recommendations to (Pre) School, Child Care, or Early Intervention Personnel	Summary of Findings (check one): <input type="checkbox"/> Well child; no conditions identified of concern to school program activities <input type="checkbox"/> Conditions identified that are important to schooling or physical activity (complete sections below and/or explain here):	
	Allergy: <input type="checkbox"/> food: _____ <input type="checkbox"/> insect: _____ <input type="checkbox"/> medicine: _____ <input type="checkbox"/> other: _____ Type of allergic reaction: <input type="checkbox"/> anaphylaxis <input type="checkbox"/> local reaction Response required: <input type="checkbox"/> none <input type="checkbox"/> epinephrine auto-injector <input type="checkbox"/> other: _____ Individualized Health Care Plan needed (e.g., asthma, diabetes, seizure disorder, severe allergy, etc) _____ Restricted Activity Specify: _____ Developmental Evaluation <input type="checkbox"/> Has IEP <input type="checkbox"/> Further evaluation needed for: _____ Medication. Child takes medicine for specific health condition(s). <input type="checkbox"/> Medication must be given and/or available at school. Special Diet Specify: _____ Special Needs Specify: _____ Other Comments: _____	

Health Care Professional's Certification (Write legibly or stamp) ☐ 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: _____

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) <input type="checkbox"/> 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.):** ____/____/____