The Child & Family Network Centers (CFNC)
Pre-Kindergarten Registration Checklist (Page 1 of 2)

Important Dates

<table>
<thead>
<tr>
<th>April 12</th>
<th>Early Registration Ends</th>
<th>July-August</th>
<th>Acceptance Notifications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>September 6</td>
<td>First Day of School</td>
</tr>
</tbody>
</table>

When you come to register your child, please bring ALL of the required documents listed:

- HOME LANGUAGE SURVEY
- CFNC STUDENT REGISTRATION FORM
- STUDENT HEALTH INFORMATION FORM
- ORIGINAL BIRTH CERTIFICATE (or a Certified Birth Certificate)
- PROOF OF GUARDIANSHIP (Proof that the adult registering the child is the Parent/Legal Guardian)
  - Name on birth certificate should match the parent/guardian’s picture ID or court documents of legal custody.
- COMMONWEALTH OF VIRGINIA SCHOOL ENTRANCE HEALTH FORM
  
  **PHYSICAL EXAMINATION REPORT**
  State law (Ref. Code of Virginia § 22.1-270) requires that your child receives a comprehensive physical examination in the United States before entering preschool in a public elementary school. Physical examination must be dated within one year prior to date of entry into preschool.

  **IMMUNIZATION RECORDS (Documenting month, day and year each was administered)**
  
  - **HEPATITIS B**
    - A complete series of three doses of Hepatitis B vaccine is required for all children.
  
  - **Diphtheria, Tetanus, Pertussis (Dtap, DTP or Tdap)**
    - A minimum of four doses, with one dose administered on or after the fourth birthday.
  
  - **POLIO (OPV or IPV)**
    - A minimum of four doses, with one dose administered on or after the fourth birthday.
  
  - **Measles, Mumps, & Rubella (MMR)**
    - All children must have at least two doses of Measles, two doses of Mumps and one dose of Rubella prior to kindergarten. The first doses must be administered at 12 months of age or older.
  
  - **Varicella (Chicken Pox)**
    - All children must have two doses of varicella or medical documentation of having the chicken pox disease.
  
  - **Haemophilus Influenzae (Hib)**
    - 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). Unvaccinated children between the ages of 15 and 60 months are only required to have one dose of vaccine.
  
  - **Pneumococcal Vaccine (PCV)**
    - This vaccine is required ONLY for children less than 60 months of age. One to four doses, dependent on age of first dose of pneumococcal conjugate vaccine required.

**IMPORTANT IF IMMUNIZATIONS ARE DEFICIENT:** If new vaccines have just been administered, a licensed health care provider must advise in writing the date of the next scheduled visit for additional vaccines. Also, proper spacing of doses should be followed. When additional vaccines are received, written documentation needs to be provided to the school nurse.

**See Reverse Side**
PROOF OF RESIDENCY
You MUST submit any ONE of the following documents for verification of current residency; they must be dated within the past 60 days, and only originals are accepted (no copies):
- Lease agreement
- Mortgage contract or payment receipt with address indicated
- Utility bill (water, gas, electric, cable, or landline phone)
- Personal property tax bill or receipt

NOTE: A driver’s license or state-issued ID does NOT serve as valid proof of residency. If you reside with someone else, you will be required to complete the ACPS Residency Affidavit, Notarized Form A and B, and submit a copy of the householder’s lease agreement and a utility bill.

INCOME VERIFICATION
Please supply one of the following:
- Income Tax Form 1040
- Written Statement from Employer
- W-2 (from recent year)
- Supplemental Security Income (SSI)
- 2 recent pay stubs
- Temporary Assistance for Needy Families (TANF)
- Unemployment Compensation
- Foster Care Reimbursement
- Notarized Income Verification
Home Language Survey

Parent/Guardian: Federal regulations require school systems to survey all enrolling students regarding the students’ home language and any other languages the students may speak. Based on the information provided below, the student may be assessed for English proficiency as required by federal regulations. Based on the results of the assessment, the student may be eligible for supplemental instruction through the English Learner (EL) program. Parents/guardians will be informed about the assessment results and if the student is eligible for supplemental services, the parents will have the opportunity to accept or refuse the supplemental EL services.

Padre, madre o tutor legal: Las leyes federales requieren que los sistemas escolares encuesten a todos los alumnos sobre el idioma que se habla en el hogar y sobre cualquier otro idioma que puedan hablar los alumnos. Con base en la información proporcionada a continuación, el alumno pudiera ser evaluado para determinar su competencia en el idioma inglés tal como lo exigen las normas federales. Con base en los resultados de la evaluación, el alumno pudiera ser elegible para recibir instrucción suplementaria mediante el programa de Aprendizaje del Idioma Inglés (EL). Se informará a los padres o tutores legales sobre los resultados de la evaluación y si el alumno es elegible para recibir servicios suplementarios, los padres tendrán la oportunidad de aceptar o rechazar los servicios suplementarios de EL.

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

¿Cuál es el idioma principalmente utilizado en el hogar, independientemente del idioma que el alumno hable?

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

¿Cuál es el idioma que el alumno habla con más frecuencia?

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

¿Cuál es el idioma que el alumno aprendió primero?

In which language do you prefer to receive communication from the school? ☐ English ☐ Español ☐ العربية

¿En qué idioma prefiere recibir comunicación de la escuela?

☐ Other: __________________________

☐ Otro

☐ أخرى

Parent/Guardian Signature: __________________________

Firma del padre, madre o tutor legal

Date: __________________________

Fecha

Translation:

Who is the student’s primary language used in the home, regardless of the language spoken by the student? __________________________

¿Cuál es el idioma principalmente utilizado en el hogar, independientemente del idioma que el alumno hable?

What is the language most often spoken by the student? __________________________

¿Cuál es el idioma que el alumno habla con más frecuencia?

What is the language that the student first acquired? _______________________________________________________________

¿Cuál es el idioma que el alumno aprendió primero?

In which language do you prefer to receive communication from the school? ☐ English ☐ Español ☐ العربية

¿En qué idioma prefiere recibir comunicación de la escuela?

☐ Other: __________________________

☐ Otro

☐ أخرى

Parent/Guardian Signature: __________________________

Firma del padre, madre o tutor legal

Date: __________________________

Fecha
### STUDENT INFORMATION

| Student’s Last Name: ________________________ | First Name: ________________________ | Middle Name: ________________________ |

| Student and Primary Parent/Guardian Address: Street ________________________ | Apt # ________________________ |

| City ________________________ | State ________________________ | Zip ________________________ |

- □ Male  □ Female  
- Date of Birth: Mo: _______ Day: _______ Year: _______  
- Country of Birth: ________________________  
- Grade: ________________________

**Is this student Hispanic or Latino? (choose only one)**
- □ No, not Hispanic or Latino  
- □ Yes, Hispanic or Latino (person of Cuban, Mexican, Puerto Rican, South American, Central American, or other Spanish culture or origin, regardless of race)

**What is the student’s race? (choose one or more)**
- □ American Indian/Alaskan  
- □ Black or African American  
- □ Asian  
- □ Native Hawaiian or Other Pacific Islander  
- □ White (a person having origins in any of the original peoples of Europe, the Middle East or North Africa)

**If a language other than English is spoken in the student’s home, what is that language?**
- □ Spanish  
- □ Amharic  
- □ Arabic  
- □ Other (please specify) ________________________

### PARENT/GUARDIAN INFORMATION

**Primary Parent/Guardian:**  
*This is the parent/legal guardian with whom the student lives most of the week, and the main contact regarding the student.*

- Do you live/reside in the City of Alexandria? □ Yes □ No  
- If No, has an exception to policy been approved? □ Yes □ No

| Last Name: ________________________ | First Name: ________________________ | □ Male □ Female |

- □ Father  □ Stepfather  □ Legal Guardian  
- □ Mother  □ Stepmother  □ Foster Parent

**Other (please indicate relationship): ________________________

| Home Phone: (_____) _____ - _______ | Is your home phone a cell phone? □ Yes □ No |

| Cell Phone: (_____) _____ - _______ |

| Email Address: ________________________ |

**Parent/Guardian’s preferred language of communication?**
- □ English  
- □ Spanish  
- □ Amharic  
- □ Arabic  
- □ Other (please specify) ________________________

| Country of Birth: ________________________ |

| Highest Education Level: □ Elementary School □ Middle School □ High School □ College □ Graduate School |

**Parent/Guardian Level #2:**

| Last Name: ________________________ | First Name: ________________________ | □ Male □ Female |

- □ Father  □ Stepfather  □ Legal Guardian  
- □ Mother  □ Stepmother  □ Foster Parent

**Other (please indicate relationship): ________________________

| Address: □ Address is the same as student and primary parent/guardian’s address above |

| Street ________________________ | Apt # ________________________ |

| City ________________________ | State ________________________ | Zip ________________________ |

| Home Phone: (_____) _____ - _______ | Is your home phone a cell phone? □ Yes □ No |

| Cell Phone: (_____) _____ - _______ |

| Email Address: ________________________ |

| Country of Birth: ________________________ |

| Highest Education Level: □ Elementary School □ Middle School □ High School □ College □ Graduate School |
# STUDENT REGISTRATION FORM  •  Page 2 of 2

## STUDENT BACKGROUND

Does your child have a current IEP for Special Education services or 504 Plan?  
☐ Yes  ☐ No  
If Yes, has documentation been provided to the school?  
☐ Yes  ☐ No

## STUDENT’S SIBLINGS and other household members

<table>
<thead>
<tr>
<th>Name</th>
<th>Birth Date</th>
<th>Sex</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Authorized Release List

Please list the persons who may pick up your child from CFNC. Include carpool drivers, neighbors, grandparents, etc. The person picking up your child may be asked to provide some identification.

**Contact #1**

Name: ________________________________

Home Phone: (______) ______-_________  Cell Phone: (______) ______-_________

Relationship to student: ________________________________

**Contact #2**

Name: ________________________________

Home Phone: (______) ______-_________  Cell Phone: (______) ______-_________

Relationship to student: ________________________________

**Contact #3**

Name: ________________________________

Home Phone: (______) ______-_________  Cell Phone: (______) ______-_________

Relationship to student: ________________________________

**Contact #4**

Name: ________________________________

Home Phone: (______) ______-_________  Cell Phone: (______) ______-_________

Relationship to student: ________________________________

Please list the persons who may NOT pick up your child from CFNC. If a parent is listed, appropriate legal documents will be required.

Name: ________________________________

Name: ________________________________

Name: ________________________________

By signing this form I am verifying that the information contained herein is correct.

Parent/Guardian Signature: ________________________________  Date: ________________________________

## FOR OFFICE USE ONLY

<table>
<thead>
<tr>
<th>Student ID</th>
<th>School ID</th>
<th>Sch/Res</th>
<th>Att/Permit Code</th>
<th>Address/Transfer Permit Verified</th>
<th>Grade</th>
<th>Entry Code</th>
<th>Entry Date</th>
<th>Office Verification/Signature</th>
</tr>
</thead>
</table>

Revised 1/2017 Communications Office dnbm
STUDENT HEALTH INFORMATION FORM • PAGE 1 OF 2

Student’s Last Name: ___________________________ First Name: ___________________________

Date of Birth: ___________________________ Grade: ___________________________ School Year: ___________________________

Please list at least two people we may call to make emergency decisions and/or pick up your child from school if the parent(s)/guardian(s) cannot be reached in the event of an emergency:

**Emergency Contact #1 (Other than Parent/Guardian):**
- Name: ___________________________
- Address: Street ___________________________ Apt # ___________________________
  - City ___________________________ State ___________________________ Zip ___________________________
- Home Phone: (_____ ) _____-_______ Cell Phone: (_____ ) _____-_______
- Work Phone: (_____ ) _____-_______
- Relationship to student: ___________________________

**Emergency Contact #2 (Other than Parent/Guardian):**
- Name: ___________________________
- Address: Street ___________________________ Apt # ___________________________
  - City ___________________________ State ___________________________ Zip ___________________________
- Home Phone: (_____ ) _____-_______ Cell Phone: (_____ ) _____-_______
- Work Phone: (_____ ) _____-_______
- Relationship to student: ___________________________

**STUDENT HEALTH CONDITIONS**
Check all boxes that apply to the student.

**ALLERGIES**
- Yes [ ] No [ ]

**Allergy Type:**
- Food List food(s): ___________________________
- Medication List medication(s): ___________________________
- Bee stings or insect bites
- Other: ___________________________

**Date of last severe reaction:**
_________________________

**FOOD RESTRICTIONS**
- Yes [ ] No [ ]

- Due to Gastrointestinal (Digestive) distress List food(s): ___________________________
- Due to religious or other preferences List food(s): ___________________________

**ASTHMA**
- Yes [ ] No [ ]

**Currently prescribed medications and treatments for asthma:**
- Daily control (prevention) medication
- As needed (rescue) medication

**Date of last hospital or emergency room visit due to asthma:**
_________________________
In the case of an emergency, school staff will call 911. Every attempt will be made to contact a parent, legal guardian or emergency contact.

The parent/guardian is responsible for providing the school with any medication, special food or equipment that the student requires during the school day. Check with the school nurse or registrar to obtain correct medication and procedural forms. If an individual school health care plan is indicated, the parent/guardian is responsible for providing the school nurse with necessary medical information, appropriate authorization forms and written consent to exchange information with the child’s physician.

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.

Parent/Guardian Signature: _______________________________ Date: _______________________________
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                 First                           Middle

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: _____-_____-______

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

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)</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>*Pneumococcal (PCV conjugate)</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</td>
</tr>
<tr>
<td>*Rubella</td>
<td>1</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</td>
</tr>
<tr>
<td>Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:</td>
<td></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.): ___/___/____
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/Tdap: [ ]; DT/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-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.)

Certification of Immunization 03/2014
### 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.

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

**Physical Examination**

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

**HEENT**

- [ ] Otitis media
- [ ] Sinusitis
- [ ] Nasal obstruction
- [ ] Vision
- [ ] Hearing
- [ ] Lungs
- [ ] Abdomen
- [ ] Genital
- [ ] Heart
- [ ] Extremities
- [ ] Urinary

**Developmental Screen**

- [ ] Emotional/Social
- [ ] Problem Solving
- [ ] Language/Communication
- [ ] Fine Motor Skills
- [ ] Gross Motor Skills

**Vision Screen**

- [ ] Screened by OAE (Otoacoustic Emissions): [ ] Pass [ ] Refer
- [ ] With Corrective Lenses (check if yes)
- [ ] Stereopsis
- [ ] Distance: Both R L
- [ ] Test used: 20'

**Hearing Screen**

- [ ] Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.
- [ ] R
- [ ] L
- [ ] TST/IGRA Result: [ ] Positive [ ] Negative
- [ ] Test for TB Infection: TST IGRA Date: _____
- [ ] TST/IGRA Reading mm
- [ ] CXR Date: _______
- [ ] CXR required if positive test for TB infection or TB symptoms.
- [ ] EPSDT Screens Required for Head Start – include specific results and date:
- [ ] Blood Lead: __________________________________________
- [ ] Hct/Hgb: __________________________________________
- [ ] Blood Pressure: BP
- [ ] Body Mass Index (BMI): ___________
- [ ] Date of Assessment: _____/_____/_____

**Other Comments:**

- [ ] Allergy: food: ____________________ insect: ____________________ medicine: ____________________ other: ____________________
- [ ] Type of allergic reaction: anaphylaxis: local reaction: Response required: none epinephrine auto-injector: 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: ____________________

### 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: Individualized Health Care Plan needed: (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)
  - [ ] Restricted Activity Specify:
  - [ ] Developmental Evaluation: [ ] Has IEP [ ] Further evaluation needed for:
  - [ ] Medication: Child takes medicine for specific health condition(s): [ ] Medication must be given and/or available at school.
  - [ ] Special Diet Specify:
  - [ ] Special Needs Specify:

**Other Comments:**

### Health Care Professional’s Certification

(Write legibly or stamp) [ ] By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).

**Name:** __________________________  **Signature:** __________________________  **Date:** _____/_____/_____

**Practice/Clinic Name:** __________________________  **Address:** __________________________

**Phone:** _____ - _____ - _____  **Fax:** _____ - _____ - _____  **Email:** __________________________
The City of Alexandria, Alexandria City Public Schools, and local preschool providers are working together to connect qualifying families to free or low-cost education program

Eligibility Requirements
- Child must turn 4 years old by September 30th
- Families must meet income requirement
- Families must reside in the City of Alexandria

Preschool Resources
- Alexandria City Public Schools (ACPS) 703-619-8026
- The Child and Family Network Centers (CFNC) 703-836-0214
- The Campagna Center (TCC) 703-549-0111
- ALIVE! 703-548-9255
- Creative Play School 703-751-3388
- DCHS Early Childhood Program 703-746-5437

Required Documents
- Registration forms
- Photo I.D. of parent registering child
- Child's original birth certificate
- Commonwealth of Virginia Health Entrance form
  - Completed Physical Exam
  - Immunization records
  - Tuberculosis test
- Proof of residency in the City of Alexandria
- Proof of income

High quality, free or low-cost preschool opportunities for qualifying families
# Preschool Locations/Listings

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>CLASSROOM NAME</th>
<th>ADDRESS</th>
<th>HOURS OF OPERATION</th>
<th>CLASS SIZE</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CFNC</td>
<td>Wheeler 1 &amp; 2</td>
<td>3700 Wheeler Ave. Alexandria VA 22304</td>
<td>9:00am to 4:00pm</td>
<td>2 classrooms, 18 students per class</td>
<td>4</td>
</tr>
<tr>
<td>CFNC</td>
<td>Chirilagua</td>
<td>3918 A Bruce St. Alexandria, VA 22305</td>
<td>9:00am to 4:00pm</td>
<td>1 classroom, 18 students</td>
<td>4</td>
</tr>
<tr>
<td>CFNC</td>
<td>CFNC on King Street</td>
<td>2723 King St. Alexandria, VA 22302</td>
<td>9:00am to 4:00pm</td>
<td>1 classroom, 15 students</td>
<td>4</td>
</tr>
<tr>
<td>CFNC</td>
<td>3801 Mt. Vernon</td>
<td>3801 Mt. Vernon Ave. Alexandria, VA 22305</td>
<td>9:00am to 4:00pm</td>
<td>1 classroom, 16 students</td>
<td>4</td>
</tr>
<tr>
<td>CFNC</td>
<td>Cora Kelly Rec Center</td>
<td>25 W. Reed Ave. Alexandria, VA 22305</td>
<td>9:00am to 3:00pm</td>
<td>2 classrooms, 18 students per class</td>
<td>4</td>
</tr>
<tr>
<td>CFNC</td>
<td>Cora Kelly School</td>
<td>3600 Commonwealth Ave. Alexandria, VA 22305</td>
<td>9:00am to 3:00pm</td>
<td>1 classroom, 16 students</td>
<td>4</td>
</tr>
<tr>
<td>ALIVE!</td>
<td>ALIVE! Child Development Blue Room</td>
<td>2723 King St. Alexandria, VA 22302</td>
<td>6:45am to 5:45pm</td>
<td>1 classrooms, 16 students</td>
<td>4</td>
</tr>
<tr>
<td>ALIVE!</td>
<td>ALIVE! Child Development Red Room</td>
<td>2723 King St. Alexandria, VA 22302</td>
<td>6:45am to 5:45pm</td>
<td>1 classrooms, 14 students</td>
<td>3-4</td>
</tr>
<tr>
<td>ACPS</td>
<td>Early Childhood Center</td>
<td>5651 Rayburn Ave. Alexandria, VA 22311</td>
<td>8:00am to 2:35pm</td>
<td>6 classrooms, 16 students per class</td>
<td>4</td>
</tr>
<tr>
<td>ACPS</td>
<td>William Ramsay School</td>
<td>4643 Taney Ave. Alexandria, VA 22311</td>
<td>8:00am to 2:35pm</td>
<td>2 classrooms, 16 students per class</td>
<td>4</td>
</tr>
<tr>
<td>ACPS</td>
<td>James Polk School</td>
<td>5000 Polk Ave. Alexandria, VA 22304</td>
<td>8:00am to 2:35pm</td>
<td>3 classrooms, 16 students per class</td>
<td>4</td>
</tr>
<tr>
<td>ACPS</td>
<td>Jefferson-Houston School</td>
<td>1501 Cameron St. Alexandria, VA 22314</td>
<td>8:00am to 2:35pm</td>
<td>1 classroom, 16 students</td>
<td>4</td>
</tr>
<tr>
<td>TCC</td>
<td>Jackson Crossing</td>
<td>120 E. Reed Ave. Alexandria, VA 22305</td>
<td>8:30am to 3:00pm</td>
<td>1 classroom, 18 students HS/VPI</td>
<td>3-5</td>
</tr>
<tr>
<td>TCC</td>
<td>Early Childhood Center</td>
<td>5651 Rayburn Ave. Alexandria, VA 22311</td>
<td>8:30am to 3:00pm</td>
<td>1 VPI classroom, 7 HS classrooms</td>
<td>3-5</td>
</tr>
<tr>
<td>TCC</td>
<td>St. James Early Learning Center</td>
<td>5140 Fillmore Ave. Alexandria, VA 22311</td>
<td>7:30am to 6:00pm</td>
<td>3 classrooms, 7 students per class</td>
<td>3-5</td>
</tr>
<tr>
<td>TCC</td>
<td>George Washington Middle</td>
<td>1005 Mt. Vernon Ave. Alexandria, VA 22311</td>
<td>7:30am to 6:00pm</td>
<td>1 HS classroom, 3 EHS classrooms</td>
<td>0-5</td>
</tr>
<tr>
<td>TCC</td>
<td>Fairlington United Methodist</td>
<td>3900 King St. Alexandria, VA 22302</td>
<td>8:30am to 3:00pm</td>
<td>1 classroom, 20 students</td>
<td>3-5</td>
</tr>
<tr>
<td>TCC</td>
<td>Jefferson-Houston School</td>
<td>1501 Cameron St. Alexandria, VA 22314</td>
<td>8:30am to 3:00pm</td>
<td>4 classrooms, 20 students per class</td>
<td>3-5</td>
</tr>
<tr>
<td>TCC</td>
<td>St. Paul’s Episcopal Church</td>
<td>228 S. Pitt ST. Alexandria, VA 22314</td>
<td>8:30am to 3:00pm</td>
<td>1 classroom, 18 students</td>
<td>3-5</td>
</tr>
<tr>
<td>TCC</td>
<td>Cora Kelly School</td>
<td>3600 Commonwealth Ave. Alexandria, VA 22305</td>
<td>8:30am to 3:00pm</td>
<td>2 classrooms, 18 students per class</td>
<td>3-5</td>
</tr>
<tr>
<td>TCC</td>
<td>T.C. Williams High School</td>
<td>3330 King St. Alexandria, VA 22302</td>
<td>7:30am to 6:00pm</td>
<td>3 EHS classrooms, 8 students per class</td>
<td>0-3</td>
</tr>
<tr>
<td>TCC</td>
<td>Family Child Care</td>
<td>511 Four Mile Rd. Alexandria, VA 22305</td>
<td>7:30am to 6:00pm</td>
<td>1 EHS classroom, 4 students</td>
<td>0-3</td>
</tr>
<tr>
<td>TCC</td>
<td>Family Child Care</td>
<td>60 S. Van Dorn St. Alexandria, VA 22304</td>
<td>7:30am to 6:00pm</td>
<td>1 EHS classroom, 4 students</td>
<td>0-3</td>
</tr>
<tr>
<td>Creative</td>
<td>Creative Play School Classroom 1</td>
<td>845 N. Howard St. Alexandria, VA 22304</td>
<td>6:45am to 6:00pm</td>
<td>1 classroom, 16 students</td>
<td>4</td>
</tr>
<tr>
<td>Creative</td>
<td>Creative Play School Classroom 2</td>
<td>100 E. Windsor Ave. Alexandria, VA 22301</td>
<td>7:00am to 6:00pm</td>
<td>1 classroom, 18 students</td>
<td>4</td>
</tr>
</tbody>
</table>