2019-2020 Kindergarten Registration

Gravely Elementary Kindergarten Registration for the 2018-2019 school year will be held on Thursday, April 4th from 5:00 – 8:00 p.m. and on Thursday, April 11th from 8:00 a.m. – 12:00 p.m.

Students who will be five years of age or older by September 30, 2019 are eligible for enrollment in kindergarten for the 2019-2020 school year. Registration will take place for those students who reside within Gravely Elementary School boundaries.

Kindly bring the following documents with you for registration:
1. A certified copy of the student’s birth certificate.
2. 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). Other examples of proofs of residency include utility bills, voter registration, etc.
3. A valid immunization record signed by a healthcare professional and a comprehensive physical exam dated within twelve months of the student’s entry into the public school system.

PLEASE NOTE: The immunization records must document:
- four doses of DTP 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 (one dose received at 12 months of age or older and the second prior to entering kindergarten and usually given as MMR);
- one dose of a rubella vaccine received at 12 months of age or older (usually given as MMR);
- two doses of mumps (one dose received at 12 months of age or older and the second prior to entering kindergarten and usually given as MMR); and
- three doses of the hepatitis B vaccine (given over a minimum four month spread).
- All susceptible children (those who have not had chicken pox) born after January 1, 1997 are also required to have one dose of varicella; effective July 1, 2008
- 2 doses of varicella vaccine shall be required for students entering Kindergarten; the first dose at age 12 months or older and the second dose can be administered at any time after the minimum interval (12 weeks) between the first dose and second dose.

All original documents will be returned to the parent.

If you are unable to attend either of the scheduled registration dates, please contact the front office after May 1st to make an appointment to register your child.
**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>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</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>10-digit Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Prince William County Public School 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>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Ethnicity – Please circle yes or no</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>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>MM / YY</td>
<td>MM / YY</td>
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</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Father’s Full Name</th>
<th>Parent, Step, Guardian, or Foster (circle as applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Military Connected: YES ☐ NO ☐ Anticipated PCS
*Member of the Armed Forces or a civilian employee of the DOD who is employed on Federal property

<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>

<table>
<thead>
<tr>
<th>10-digit Home Phone Number</th>
<th>Employed by</th>
<th>10-digit Work Phone Number</th>
<th>Ext.</th>
<th>Cell Phone Number</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Mother’s Full Name</th>
<th>Parent, Step, Guardian, or Foster (circle as applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Military Connected: YES ☐ NO ☐ Anticipated PCS
*Member of the Armed Forces or a civilian employee of the DOD who is employed on Federal property

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<th>(Apt#)</th>
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<th>State</th>
<th>Zip</th>
</tr>
</thead>
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<table>
<thead>
<tr>
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<th>10-digit Work Phone Number</th>
<th>Ext.</th>
<th>Cell Phone Number</th>
<th></th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Work Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>E-Mail Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</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. 6/14
Kindergarten Registration Only

PRESCHOOL SERVICES SURVEY
KINDERGARTEN REGISTRATION

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
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: ____________________________

Student’s Name: ____________________________

Current Grade: ____________________________

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

| Student’s Name: | Date of Birth: |  |
|-----------------|---------------|

<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></td>
</tr>
<tr>
<td>*Poliomyelitis (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>*only for children &lt;60 months of age</td>
<td></td>
</tr>
<tr>
<td>*Pneumococcal (PCV conjugate)</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>*only for children &lt;60 months of age</td>
<td></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 2   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 3</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 2</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(i), 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[ ]; 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.

**Student's Name:** [Blank]  
**Date of Birth:** [Blank]  
**Sex:** [Blank]

### 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 2 3</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
</tbody>
</table>

**HEENT**  
- [ ] No  
- [ ] Yes  

**Lungs**  
- [ ] No  
- [ ] Yes  

**Abdomen**  
- [ ] No  
- [ ] Yes  

**Genital**  
- [ ] No  
- [ ] Yes  

**Skin**  
- [ ] No  
- [ ] Yes  

**Skin**  
- [ ] No  
- [ ] Yes  

**Examinations required for Head Start – include specific results and date:**  
**Blood Lead:**  
- [ ] Elevated  
- [ ] High

### Developmental Screen

<table>
<thead>
<tr>
<th>Domain</th>
<th>Assessment Method</th>
<th>Concern identified</th>
<th>Referred for Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional/Social</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem Solving</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Language/Communication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fine Motor Skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross Motor Skills</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Hearing Screen

- [ ] Screened at 20 dB: Indicate Pass (P) or Refer (R) in each box.
- [ ] Pass  
- [ ] Fail  
- [ ] Not tested

<table>
<thead>
<tr>
<th>Test</th>
<th>R</th>
<th>L</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000</td>
<td></td>
<td></td>
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<tr>
<td>2000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Vision Screen

- [ ] With Corrective Lenses (check if yes)
- [ ] Screened by OAE (Otoacoustic Emissions):  
  - [ ] Pass  
  - [ ] Refer

<table>
<thead>
<tr>
<th>Distance</th>
<th>R</th>
<th>L</th>
<th>Test used:</th>
</tr>
</thead>
<tbody>
<tr>
<td>20/20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20/20</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- [ ] 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

### 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  
- [ ] Asthma  
- [ ] Asthma  
- [ ] Other:

- [ ] Type of allergic reaction:  
- [ ] 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:

### 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:** [Blank]  
**Signature:** [Blank]  
**Date:** [Blank]

**Practice/Clinic Name:** [Blank]  
**Address:** [Blank]

**Phone:** [Blank]  
**Fax:** [Blank]  
**Email:** [Blank]

MCH 213G reviewed 03/2014

4
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 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)
Prince William County Public Schools
Home Language Survey (HLS)

Directions for Parent/Guardian: Please enter a complete and accurate response for each number 1 through 10, using Not Applicable (N/A) when needed. If you have a question, please contact a school or office staff member who will be happy to help. Prince William County Public Schools (PWCS) offers free language support. If you are in need of a language other than English, please let us know the language or point to your language on the Language Assistance Poster.

Student’s Name (First, Last): ___________________________ Date of Birth: ____________

For questions 1-4, write all applicable languages:
1. What is the language that the student first acquired? ____________________________
2. What is the language most often spoken by the student? _________________________
3. What is the primary language used in the home, regardless of the language spoken by the student? ________________________
4. In which languages do you prefer to receive communication from the school? (Please specify)
   Verbal: English or other _____________________________________________ Written: English or other _________________________________________

5. Country of Birth
   (same as entered on Registration Form)

6. Original Date of Entry into the U.S.A.
   (if born outside the U.S.A.) ________________

7. Date of Most Recent Entry into U.S.A.
   (if applicable) ________________

8. 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

9. 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 ________________

10. 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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Name of parent/guardian who completed the form ___________________________ (Please print first and last name)

Relationship to Student ___________________________

Parent/guardian signature: ___________________________ Date ________________

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 1783 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.

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 Woodbridge or Manassas (circle one)
Date Sent to CRS ________________

Routing: CRS Instructions
Date Received by CRS ________________ Initials ___________________________
Date sent to Dept. Chair/Lead Teacher ___________________________

Home Language Identified in SMS
Dates updated in SMS / / ________________

Home Language Identified in IMS
Note: If school registrar completes the home language fields in IMS, please use guidance provided in PowerSchool SMS Training and Enrollment Manual.

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