To be completed by School:

Teacher Assignment _____ Homeroom _____ Bus _____

STI _____ Student ID # _____

Date _____ School Year _____ /_____

FREDERICKSBURG CITY PUBLIC SCHOOLS – REGISTRATION FORM

Has student previously attended Fredericksburg City Public Schools? ☐ **Yes** ☐ **No**

If yes, name of school _____

STUDENT'S NAME: _____ _____ _____

(Last) (First) (Middle)

STUDENT'S PREFERRED NAME: _____ GRADE: _____

Gender:
☐ **Male**
☐ **Female**

DOB: **BIRTHPLACE: CITY** **STATE** **COUNTRY**

MILITARY CONNECTED: NAT'L GUARD OR RESERVES

CHANGE

DEPENDENT STATUS ☐ **Not military connected** ☐ **Active Duty Fulltime** ☐**Nat' Guard or Rerserve**

ADDRESS: _____ _____

(Street) **(Apt. #)**

_____

(City) **(State)** **(Zip Code)**

Are you in a temporary living situation ☐ **Yes (If yes, check nighttime residence)** ☐ **No**

Nighttime residence: ☐ **Motel/Camper/Trailer** ☐ **Car or public building** ☐ **Awaiting Foster Care**
☐ **Shelter** ☐ **Living with another family due to loss of housing or financial hardship**

STUDENT LIVES WITH: (Check all that apply)

☐ **Father** ☐ **Mother** _____
(First, MI, Last)

☐ **Mother** ☐ **Father** _____
(First, MI, Last)

☐**Stepmother** _____
(First, MI, Last)

☐**Stepfather** _____
(First, MI, Last)

☐ **Guardian** _____
(First, MI, Last)

☐ **Fosterparent** _____
(First, MI, Last)

Referring Agency _____

ETHNICITY: (Check One)
☐ **Hispanic or Latino**
☐ **Not Hispanic or Latino**

RACE: (Check all that apply)
☐ **American Indian/Alaskan Native**
☐ **Black or African American**
☐ **White**
☐ **Native Hawaiian/Other**
☐ **Pacific Islander**
☐ **Asian**

Translation Required
☐ **Yes** ☐ **No**

NON-CUSTODIAL PARENT'S INFORMATION: (if applicable)

Name _____ Address _____

Court Order on file? ☐ **Yes** ☐ **No** City, State, Zip _____

(Please complete information on both sides of this form)

CONTACT INFORMATION

TELEPHONE	☐ MOTHER ☐ FATHER ☐ OTHER	☐ MOTHER ☐ FATHER ☐ OTHER
HOME PHONE #		
CELL #1		
CELL #2		
WORK PHONE #		
E-MAIL		
OTHER		

EMERGENCY CONTACT INFORMATION (AUTHORIZED PERSONS WHO MAY PICK UP YOUR CHILD - OTHER THAN PARENT)

NAME	TELEPHONE	RELATIONSHIP

MEDICAL INFORMATION

Dr. Name	Phone Number
Dentist	Phone Number

SIBLINGS ATTENDING FREDERICKSBURG SCHOOLS

NAME (First, MI, Last)	GRADE	SCHOOL

TRANSPORTATION TO/FROM SCHOOL

Morning

☐ Car ☐ Walk

☐ Day Care Van

☐ School Bus: _____

(pick up address)

Afternoon ☐ Walk

☐ Car

☐ Day Care Van

☐ School Bus: _____

(drop off address)

Name of Last School Attended: _____

Address: _____

Special Services Received: ☐ Special Ed ☐ 504 Plan ☐ Speech ☐ Gifted ☐ English Second Language

PLEASE COMPLETE INFORMATION ABOUT YOUR CHILD'S PRE-SCHOOL EXPERIENCE

My Child attended pre-school at: ☐ Private Provider ☐ Head Start ☐ VPI ☐ Title 1 - PRE K ☐ Licensed Home/Day Care ☐ Coordinated SPED ☐ SPED only ☐ No formal PRE-K ☐ Government - Tuition Charged ☐ Not provided

How many hours per week did your child attend pre-school?

☐ Less than 15 hrs./week ☐ 15 - 29 hrs./week ☐ 30 or more hrs./week

REGISTRATION FORM STATEMENT: I hereby swear and affirm that the student named on the front of this form has not been expelled from school attendance at a private school or in a public school division of the Commonwealth or another state for an offense or violation of School Board policies relating to weapons, alcohol or drugs, or for the willlful infliction of injury to another person. I understand that any person making a materially false statement of affirmation shall be guilty upon conviction of a Class 3 misdemeanor.

Parent Signature _____ **Date** _____

Student Signature (grades 6-12) _____ **Date** _____

Revised 02/16

(Please complete information on both sides of this form)

❒ Hugh Mercer Elementary School
2100 Cowan Blvd.
Phone: (540)372-1115
Fax: (540)372-6753

❒ Lafayette Upper Elementary School
3 Learning Lane
Phone: (540)310-0029
Fax: (540)310-0671

❒ Walker Grant Middle School
1 Learning Lane
Phone: (540)372-1145
Fax: (540)361-4078

❒ James Monroe High School
2300 Washington Ave.
Phone: (540)372-1100
Fax: (540)373-6584

Fredericksburg City Public Schools
210 Ferdinand Street
Fredericksburg, VA 22401
fxbgschools.us

Date_____

TO: ✶_____ _____
Name of Previous School School Phone #

_____ _____
Address of School School FAX #

_____
City State Zip

REQUEST FOR PERMISSION TO RELEASE SCHOOL RECORDS

The following student has enrolled in Fredericksburg City Public Schools.

✶ Name of Student _____

✶ Date of Birth _____ ✶ Grade _____

✶ _____
Parent's Signature

DO NOT WRITE BELOW THIS LINE

Please send us the information below including all Category I and Category II (confidential) records. Also include an interpretation of your grading system. **If the student withdrew after the start of a grading period, please indicate the grades earned for that period.**

- ❒ State Testing Identifier
- ❒ Cumulative Record
- ❒ Health and Immunization Records
- ❒ Discipline Files
- ❒ SOL Test Results
- ❒ Career/Academic Plan (MS and HS only)
- ❒ Confidential Data (IEP, eligibility minutes, testing information, social history)
- ❒ ESL Records
- ❒ Grades to Date of Withdrawal
- ❒ Birth Certificate

Faxed on: _____ ❒ 1st Request ❒ 2nd Request

Thank you for your cooperation,

_____ _____
Registrar's Signature Date

Please note that parental permission is no longer required when records are requested by authorized school personnel. (Family Educational Rights and Privacy Act, Final Rule on Education Records, Federal Register, June 17, 1976, Vol. 41, No. 118, page 24673.)

FREDERICKSBURG CITY PUBLIC SCHOOLS

DEPARTMENT OF CURRICULUM AND INSTRUCTION

HOME LANGUAGE SURVEY

This form must be completed for **ALL** students enrolling in Fredericksburg City Public Schools.

Student Name _____ **Date of Birth** _____
first middle last

PART A

1. **What is the primary language used in the home, regardless of the language spoken by the student?** _____
2. **What is the language most often spoken by the student?** _____
3. **What is the language that the student first acquired?** _____
4. **What is the date the child first enrolled in a U.S. school?** _____
5. **What is the date the child first enrolled in a Virginia school?** _____
6. **What is the last school the child attended in Virginia?** _____
7. **Has the child ever received ESL services?** ☐ **Yes** ☐ **No If yes, where?** _____

If the student was born, or has lived, outside of the United States, please complete Part B.

PART B

1. **How many years of school did the child attend in his/her native country?** _____
2. **Last grade level the child completed in his/her native country:** _____
3. **Date the child entered the United States:** _____
4. **Last grade level the child completed in a U.S. school:** _____
5. **Is your family in the U.S. seeking refuge from persecution in your native country?** ☐ **Yes** ☐ **No**

This procedure meets federal requirements for identifying and assessing language minority students in order to provide appropriate instructional support services for those students found to be English language learners. If appropriate, the student will be screened for English language proficiency. Parents or guardians will be notified of the results of the English language proficiency assessment.

Signature of Parent/Guardian	Date	Printed Name	Phone Number

FCPS ANNUAL HEALTH HISTORY UPDATE

Student's Name _____ Date of Birth _____ Grade _____
Mother/Guardian_____ Cell Phone _____ Work Phone_____
Father/Guardian_____ Cell Phone _____ Work Phone_____
Emergency Contact_____ Cell Phone _____ Work Phone_____
Physician _____ Phone _____

☐New to FCPS. If yes, last school attended: _____ State: _____

☐**Current 504 plan** ☐**Current IEP**

Does your child take any medication on a routine basis? ___YES ___ NO
Name of medication: _____ Purpose: _____ Takes at home☐ Takes at school☐
Name of medication: _____ Purpose: _____ Takes at home☐ Takes at school☐
Name of medication: _____ Purpose: _____ Takes at home☐ Takes at school☐

Please contact the school nurse if your child must take any prescription or over the counter medications at school.

NO	YES	CONDITION	COMMENTS
		ADD/ADHD	
		ALLERGIES ☐ EpiPen at home ☐ EpiPen at school	☐ Bees/Insect allergy ☐ Lactose Intolerance ☐ Food Allergy:_____ ☐ Medication Allergy_____ ☐ Other_____
		ASTHMA	Rescue inhaler: ☐ at home ☐ at school in clinic ☐ at school with student Nebulizer: ☐ at home ☐ at school in clinic ***Current Asthma Care Plan must be on file every school year if medications are needed at school.**
		BLADDER/BOWEL PROBLEMS	Please explain:
		DIABETES	☐TYPE 1 ☐TYPE 2 ***Students with diabetes must have a current Diabetes Care Plan on file at school every year.**
		HEART PROBLEMS	Please explain:
		PHYSICAL LIMITIATIONS	☐Special equipment needed at school. Please list:
		SEIZURES	☐As an infant. ☐Currently on seizure medications at home. ☐Requires emergency seizure medication at school.
		SPEECH PROBLEMS	Please explain:
		VISION/HEARING PROBLEMS	☐Glasses ☐Contacts ☐Hearing aid
		OTHER	

Parent/Guardian Signature_____Date_____

Fredericksburg City Public Schools

Screening Created by PD 16 School Health TEAM

TUBERCULOSIS RISK ASSESSMENT FOR ALL NEW STUDENTS - CONFIDENTIAL

NAME: _____ **GRADE/SCHOOL**: _____

PARENT/GUARDIAN: _____ **DATE**: _____

The United States Public Health Service and the Centers for Disease Control and Prevention (CDC) recommend that tuberculosis (TB) testing be performed on all individuals who may be at increased risk of TB. Please complete the following form.

1. Was the student born in a country outside of the United States?
   ____ No ____ Yes If yes, what country? _____
2. Has the student spent three or more consecutive months in a foreign country in the last five years?
   ____ No ____ Yes If yes, what country? _____
3. Has the student been exposed to or had contact with a person with active TB in the last year?
   ____ No ____ Yes If yes, who? _____
4. Was the student homeless/incarcerated or did he/she live in a shelter during the last two years?
   ____ No ____ Yes
5. Does the student have any of the following: persistent cough, coughed up blood, fever for more than one week, unexplained weight loss or HIV infection?
   _____ No ____ Yes If yes, please explain: _____
6. Is the student currently taking oral steroid medication (other than inhalers), cancer treating drugs or any other medication that might weaken his/her immune system?
   ____ No ____ Yes If yes, please explain: _____
7. Has the student ever had a positive test for TB or been treated for active TB disease or latent TB infection?
   ____ No ____ Yes If yes, please provide details: _____
   _____
   _____
8. Does the student have any of the following medical conditions?

a.	Diabetes	No	Yes	f. Gastrectomy	No	Yes
b.	Malnutrition	No	Yes	g. Silicosis	No	Yes
c.	Cancer	No	Yes			
d.	Chronic renal failure	No	Yes			
e.	Congenital or acquired Immunodeficiency	No	Yes			

INSTRUCTIONS FOR HEALTHCARE PROVIDER: Please complete the following when the risk assessment contains one or more positive (yes) answers. Return to the school nurse.

Date of TB test: _____ -Type of TB Test: TB skin test **OR** IGRA (interferon gamma release assay)

Test result: _____ mm induration (for TST) **OR** IGRA result: Positive Negative Indeterminate

CXR ordered? No____ Yes____ -If yes, result: _____

Treatment provided? No____ Yes____ -If yes, what? _____

Name of Health Care Provider (please print): _____

Address: _____

Telephone: _____

Signature: _____

Revised March 2015

I. Students entering school for the first time or returning after three months outside the United States must provide documentation from a licensed physician, nurse practitioner, physician assistant or registered nurse prior to entry of a:

A. TB Risk Assessment documenting low risk for TB disease. All answers on the Risk Assessment should be negative. BCG vaccination does not exclude student from following protocol. **– OR –**

B. Documentation of a negative TB (Mantoux) skin test or interferon gamma release assay within the past 12 months or after exposure. **– OR –**

C. Written documentation of having successfully completed treatment for active tuberculosis disease.

II. Students shall be excluded from school until the TB policy requirement is met. As part of the risk assessment and targeted screening process, questions arise concerning the definition "high prevalence country" for the purposes of completing the risk assessment tool and determining who should receive a test for tuberculosis (either a tuberculin skin test (TST) or interferon gamma release assay (IGRA).

III. Countries at low-risk for tuberculosis (defined as less than 20 TB cases per 100,000 population)

Current Exception List – March 2015 **(case rates from WHO 2014 Global Report)** **Test for Latent TB Infection Only if Symptomatic or an Additional Individual Risk Factor is Present**					
African Region	**American Region**	**Eastern Mediterranean**	**European Region**	**Western Pacific Region**	**Southeast Asia Region**
Egypt	Antigua & Barbuda Antilles Aruba Bahamas Barbados Bonaire, Saint Eustatius and Saba Canada Caymen Islands Chile Costa Rica Cuba Curacao Dominica Grenada Jamaica Montserrat Puerto Rico Saint Kitts & Nevis Saint Lucia Sint Maarten (Dutch Part) Turks & Caicos United States Virgin Islands (US & BR)	Bahrain Israel Jordan Lebanon Oman Saudi Arabia Syrian Arab Republic United Arab Emirates West Bank and Gaza Strip	Albania Andorra Austria Belgium Croatia Cyprus Czech Republic Denmark Finland Former Yugoslav Republic of Macedonia France Germany Greece Hungary Iceland Ireland Italy Luxembourg Malta Monaco Netherlands Norway San Marino Serbia Slovakia Spain Sweden Switzerland Turkey United Kingdom	American Samoa Australia Cook Islands Japan New Caledonia New Zealand Niue Samoa Tokelau Tonga Wallis & Futuna Islands	No exception countries