**Powell Valley Christian School**

**187 Stairway Drive, Dryden, VA 24243**

**Phone: (276) 523-0464**

**Cell: (276) 202-7747**

**powell22.adventistschoolconnect.org**

**List of needed items for Registration**

* Registration Form (completely filled out)
* Enrollment Contract (TJA Handbook)
* Health Questionnaire / Physical (Pre-K, **\***K, 3, & 6th grades)

\*Any new student or longer than 1 year ago

* Tdap Letter for 6th Graders  Registration fee
* Tuition Financial Contract
* First months tuition due the first day of school
* \*Records/Transcript Request
* \*Birth Certificate
* \*Social Security
* \*Insurance Card
* \*Immunization Record

***\*If new student at PVCS***

 Powell Valley Christian School

of Seventh-day Adventists 187 Stairway Drive

Dryden, VA 24243

**ADMISSION APPLICATION**  Phone and fax 276-523-0464

*A Christian Alternative*

*Powell Valley Christian School admits students of any race, color, religion, ethnic background, country of origin, or gender; proffers all the rights, privileges, programs, and activities generally available to students; and makes no discrimination on the basis of race, color, religion, ethnic background, country of origin or gender in administration of education policies, application for admission, scholarship programs, and athletic or extracurricular programs.*

Date: \_\_\_\_\_\_\_\_\_\_\_ School year for which you are applying: - Entering Grade: \_\_\_\_\_\_\_\_

**I. Student Information: .**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name: \_\_\_\_\_\_\_\_\_\_\_

Date of Birth: / / . Sex: M / F Student Cell Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Students Primary Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: - - .

County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Religious Affiliation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Baptized: Y / N Church: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pastor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all of the following statements that apply to your child:

\_\_\_\_\_ a. Student lives with natural parent(s) or legally adoptive parent(s).

\_\_\_\_\_ b. Parents unmarried, separated, or \*divorced. Student’s primary residence is with: Mother / Father

\_\_\_\_\_ c. Student lives apart from parents and resides with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\**Please provide a copy of any custody order or decree that has been issued with respect to the student.*

1. **Family Information: .**

**Father/Guardian’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Same address as student Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_ Home Phone: - - .

Father’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: - - . Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: - - .

**Mother/Guardian’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_ Same address as student Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_ Home Phone: - - .

Mother’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: - - . Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: - - .

1. **Person Responsible for Registration and Tuition:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_

Home Phone: - - . Cell Phone: - - . Work Phone: - - .

Email: ***Registration Payment Amt***\_\_\_\_\_\_\_\_

# Academic History: (Please fill out section IV only if your child is a new student.)

Please list all of the schools your child has previously attended beginning with the most recent. Please include the full address of each school. If more space is needed please provide the information on a separate sheet of paper

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| School Name | School Address  Street or PO Box, City, State, Zip | Phone Number | Dates:  From/To | Grade Completed |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Powell Valley Christian School is not staffed to teach children with significant physical impairments, learning disabilities or behavioral issues. Please answer the following questions to help us determine if our school is right for your child.

1. Has your child ever repeated a grade for any reason? Y / N

If yes, which grade and why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does your child have any visual loss, hearing difficulties, speech impediments, or physical impairments? Y / N If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Has your child ever been referred for testing of placed in a special program for any type of learning, behavioral or mental health issues? Y / N

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has your child ever experienced disciplinary problems at previous schools? Y / N

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The following is for all student registration:**

**For this application to be complete, all students must also submit the following:**

* Copy of original birth certificate
* Copy of original social security card
* Copy of transcript and records from previous schools or signed transcript release.

V. **Permission for Name and Picture Use: .** Please check all that apply.

\_\_\_\_\_ I give my permission for my child to use the internet at school for school related assignments.

\_\_\_\_\_ I give my permission for my child’s **picture** to be used in the **newspaper or other publications**.

\_\_\_\_\_ I give my permission for my child’s **name** to be used in the **newspaper or other publications.**

\_\_\_\_\_ I give my permission for my child’s **picture** to be used on the **PVCS website.**

\_\_\_\_\_ I give my permission for my child’s **name** to be used on the **PVCS website.**

\_\_\_\_\_ I give my permission for my child’s **picture** to be used on the  **PVCS Facebook website**.

\_\_\_\_\_ I give my permission for my child’s **name** to be used on the **PVCS Facebook website**.

\_\_\_\_\_ I give my permission for my child’s **picture** to be used in **brochures and/or CD’s for promotion of PVCS.**

Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Members of Household: .**

Please list other members of your household (Brothers, Sisters, Grandparents etc.):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Permission for Student Pick Up: .**

In case of emergency or unforeseen circumstances, I give my permission to Powell Valley Christian School to release my child to the following person(s) listed below:

Name Address Phone Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Physician/Dentist Information: .**

Family Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***(Continued on back)***

1. **Emergency, Illness and Health Information: .**

Does your child have any medical condition we should be aware of? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please indicate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| \_\_\_\_\_Asthma  \_\_\_\_\_ Medication  \_\_\_\_\_ Inhaler  \_\_\_\_\_ Arthritis  \_\_\_\_\_ Deafness  \_\_\_\_\_Diabetes  \_\_\_\_\_Allergies  \_\_\_\_\_ Bee Sting  \_\_\_\_\_Milk  \_\_\_\_\_ Penicillin  \_\_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_ Fractures (list)  Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_ Surgeries (list)  Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_ Heart Problems (list)  Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. **Continuing Consent to Treatment and Accident Insurance Information: .**

We, the undersigned parents or guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(student’s name )*a minor, do hereby consent to any x-ray examination , anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or special instructions of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(name of physician)* or any physician the school may call, whether such diagnosis or treatment is rendered at the office of said physician’s or at a licensed hospital. It is understood that reasonable effort will be made to contact the doctor’s listed above before any other physician is called by the school.

It is further understood that this consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize Powell Valley Christian School or the physician to exercise their best judgment as to the requirements of such diagnosis or treatment.

This Consent shall remain in continuous effect until revoked in writing and delivered to the physician named above or to the school entrusted with the custody of said minor.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Legal Guardian Signature: \_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Witness:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospital Preference**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

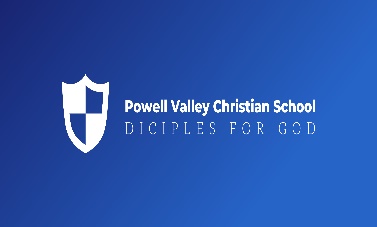
**XI. EMERGENCY CONTACT PERSON(S)**: .

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: - - . Cell Phone: - - . Work Phone: - - .

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: - - . Cell Phone: - - . Work Phone: - - .

**Powell Valley Christian School**

**Enrollment Contract**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have received and read a copy of the Powell Valley Christian School Student Handbook, which outlines the goals, policies, benefits, and expectations of PVCS, as well as my responsibilities as the parent(s) / guardian(s).

I have familiarized myself with the contents of this handbook. By signing below, I acknowledge, understand, accept, and agree to comply with the information and policies contained therein.

Further, I understand my obligations in regards to, and agree to comply with, the financial policy as outlined in this handbook.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Name and Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent(s) / Guardian(s) Name and Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent(s) / Guardian(s) Name and 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: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Name | Phone | Date of Last Appointment |
| Pediatrician/primary care provider |  |  |  |
| Specialist |  |  |  |
| Dentist |  |  |  |
| Case Worker (if applicable) |  |  |  |

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: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

**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: |\_\_\_\_|\_\_\_\_|\_\_\_\_|  *Last First* *Middle Mo. Day Yr.* | | | | | | | | |
|  | **IMMUNIZATION** | **RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN** | | | | | |  |
| \*Diphtheria, Tetanus, Pertussis (DTP, DTaP) | **1** | **2** | **3** | **4** | | **5** |
| \*Diphtheria, Tetanus (DT) or Td (given after 7 years of age) | **1** | **2** | **3** | **4** | | **5** |
| \*Tdap booster (6th grade entry) | **1** |  |  |  | |  |
| \*Poliomyelitis (IPV, OPV) | **1** | **2** | **3** | **4** | |  |
| \*Haemophilus influenzae Type b  (Hib conjugate)  \*only for children <60 months of age | **1** | **2** | **3** | **4** | |  |
| \*Pneumococcal (PCV conjugate)  \*only for children <60 months of age | **1** | **2** | **3** | **4** | |  |
| Measles, Mumps, Rubella (MMR vaccine) | **1** | **2** |  | | | |
| \*Measles (Rubeola) | **1** | **2** | Serological Confirmation of Measles Immunity: | | | |
| \*Rubella | **1** |  | Serological Confirmation of Rubella Immunity: | | | |
| \*Mumps | **1** | **2** |  | | | |
| \*Hepatitis B Vaccine (HBV)   Merck adult formulation used | **1** | **2** | **3** | |  | |
| \*Varicella Vaccine | **1** | **2** | Date of Varicella Disease OR Serological Confirmation of Varicella Immunity: | | | |
| Hepatitis A Vaccine | **1** | **2** |  | | | |
| Meningococcal Vaccine | **1** |  | | | | |
| Human Papillomavirus Vaccine | **1** | **2** | **3** | |  | |
| Other | **1** | **2** | **3** | | **4** | **5** |
| Other | **1** | **2** | **3** | | **4** | **5** |
|  |  |  |  |  | |  |  |  |
| 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* (Minimum requirements are listed in Section III).  **Signature of Medical Provider or Health Department Official: Date (*Mo., Day, Yr*.):\_\_\_/\_\_\_/\_\_\_\_**    **Certification of Immunization 11/06** | | | | | | | | |

Student’s Name: Date of Birth: |\_\_\_\_ |\_ \_\_\_|\_\_\_ \_|

***Section II***

***Conditional Enrollment and Exemptions***

**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**](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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ Sex: **□** M **□** F

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Health Assessment** | **Date of Assessment:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_  Weight: \_\_\_\_\_\_\_\_lbs. Height: \_\_\_\_\_\_\_ ft. \_\_\_\_\_\_ in.  Body Mass Index (BMI): \_\_\_\_\_\_\_\_\_\_\_ BP\_\_\_\_\_\_\_\_\_\_\_\_   * Age / gender appropriate history completed * Anticipatory guidance provided | 1 = Within normal 2 =    HEENT  Lungs Heart | 1 2  □ □  □ □  □ □ | **Physical Examination**  Abnormal finding 3 =  3 1  □ Neurological □  □ Abdomen □  □ Extremities □ | Refer  2  □  □  □ | red for evaluation or  3 1  □ Skin □  □ Genital □  □ Urinary □ | treatment  2 3  □ □  □ □  □ □ |
| **TB Screening: □ No risk for TB infection identified □ No symptoms compatible with active TB disease**  **□ Risk for TB infection or symptoms identified**  **Test for TB Infection: TST IGRA Date:\_\_\_\_\_\_\_ TST Reading \_\_\_\_\_mm TST/IGRA Result: □ Positive □ Negative**  **CXR required if positive test for TB infection or TB symptoms. CXR Date: \_\_\_\_\_\_\_\_\_\_ □ Normal □ Abnormal** | | | | | | |
| **EPSDT Screens Required for Head Start – include specific results and date:**  Blood Lead:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hct/Hgb \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |

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| --- | --- | --- | --- | --- | --- |
| **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** | * Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.  |  |  |  |  | | --- | --- | --- | --- | |  | 1000 | 2000 | 4000 | | R |  |  |  | | L |  |  |  |  * Screened by OAE (Otoacoustic Emissions): □ Pass □ Refer | □ Referred to Audiologist/ENT □ **Unable to test – needs rescreen**  □ Permanent Hearing Loss Previously identified: **\_\_\_**Left \_\_\_Right □ Hearing aid or other assistive device |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Vision**  **Screen** | * With Corrective Lenses (check if yes)  |  |  |  |  |  | | --- | --- | --- | --- | --- | | Stereopsis |  Pass |  Fail |  |  Not tested | | Distance | Both | R | L | Test used: | |  | 20/ | 20/ | 20/ |  |  * Pass  Referred to eye doctor  **Unable to test – needs rescreen** |  | **Dental**  **Screen** | * Problem Identified: Referred for treatment * No Problem: Referred for prevention * No Referral: Already receiving dental care |

|  |  |
| --- | --- |
| **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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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*187 Stairway Drive*

*Dryden, VA 24243*

*Phone & Fax (276) 523-0464*

*powell22.adventistschoolconnect.org*

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**Tdap BOOSTER TO BE REQUIRED FOR 6TH GRADE STUDENTS**

Dear Parents of Rising 6th Grade Students

As of 2006, the Virginia General Assembly passed a law which requires all 6th grade students to have tetanus, diphtheria, peruses (Tdap) booster shot prior to entry into school, if at least five years has passed since the last shot.

Please review your child’s shot record. If their last shot was before 2001 please have this done over the summer. This shot may be listed as T, Td, Dtap, and /or Tdap, call your doctor or local health department if you have questions.

Shots may be obtained from your doctor, military clinics, or the health department.

Documentation should be taken to your child’s school. You can find your local health department address via the Virginia Department of Health web page. On the top of the page you will find a link to local health districts with contact information for the district office.

Shots are free for both public and private school enrollment and documentation will be provided.

Thank you for your assistance.

Rev 07-27-20

# Powell Valley Christian School

# 187 Stairway Drive, Dryden, VA 24243

276-523-0464- www.powell22.adventistschoolconnect.org

**Pre-K – Grade 8 \*Full Price\* (Doesn’t help with fundraisers) Tuition and Fee Payments are as follows:**

**Type of Fee Amount Due Due Date**

Entrance/Book/Insurance Fees $235 08/17/2020-

Entrance/Book/Insurance Fees $250 (After 8/2020)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Entrance/Book/Insurance Fees $100 02/14/21  Entrance/Book/Insurance Fees $125 (After 2/14)  August Tuition $588 08/17/2020  September Tuition $588 09/01/2020  October Tuition $588 10/01/2020  November Tuition $588 11/01/2020  December Tuition $588 12/01/2020  January Tuition $588 01/01/2021  February Tuition $588 02/01/2021  March Tuition $588 03/01/2021  April Tuition $588 04/01/2021  May Tuition $588 05/01/2021  **Entrance/Book/Insurance Fee Refund:**  There will be no refund on entrance/book/insurance fees. The full registration fee and book fee will be charged, no matter when enrollment takes place.  **Delinquent Accounts:**  All student accounts are to be kept current. **Tuition payment is due by the 1st day of each month.** Tuition is due monthly, paid in ten payments August through May.  Tuition payments are due on the 1st of the month.  **If your payment is received on/or before to the 5th of the month, you may deduct $5.**  An account will be considered delinquent after the 5th of the month and will receive a $15.00 late fee. If payment plus late fee has not been received by the Treasurer by the 5th, or a telephone call has not been received with acceptable payment arrangements, a form letter will be sent out reminding you of the balance due and the procedures that must follow as outlined in the Student Handbook. Any student whose account is 30 days past due may be asked to withdraw from school because of non-payment unless suitable arrangements are made and approved by the School Board.  *. Powell Valley Christian School admits students of any race, color, religion, ethnic background, country of origin or gender; proffers all the rights, privileges, programs and activities generally available to students; and makes no discrimination on the basis of race, color, religion, ethnic background, country of origin or gender in administration of education policies, application for admission, scholarship programs, and athletic or extracurricular programs.*  Annual Registration/Books/Insurance Fee\*       $335.00 per year  Tuition $5,880.00 per year  Total per student              $6,215.00 per year  \*$235 of the registration fees are due at time of registration and are non-refundable and $100.00 is due in February and are non-refundable.  **\*\*Discounts for Full Price Students Only\*\***   * Payment in full for the entire year – 10% discount * Payment for the first semester/second semester – 5% discount for each semester * 12 month payment option – payment due the first of every month starting with Aug 1st. * 10 month payment option – payment due the first of every month starting with Aug 1st.   **Family Discounts** In order to assist parents having more than one child enrolled here at Powell Valley Christian School, the following monthly and yearly discounts are made for each child at Powell Valley Christian School:  1st Student 2nd Student 3rd Student 4th Student +  Full Price 10% discount 20 % discount 30% discount  $588.00 monthly $529.20 monthly $470.40 monthly $411.60 monthly  $5,880.00 yearly $5,292.00 yearly $4,704.00 yearly $4,161.00 yearly    Tuition is due monthly, paid in ten payments August through May.  Tuition payments are due on the 1st of the month.  If your payment is received on/or before to the 5th of the month, you may deduct $5 (**\*\*** no discount for Virginia Tax Scholarship tuition).  If you pay after the 5th of the month, a $15 late fee will be added.  If we deduct $5 if payment is received by the 5th of the month, you could save $50.00/$60.00 a year.  Powell Valley Christian School187 Stairway Drive, Dryden, VA 24243 276-523-0464- www.powell22.adventistschoolconnect.org  **Pre-K – Grade 8 Reduced (Help with Fundraisers) Tuition**  **and Fee Payments are as follows:**  **Type of Fee Amount Due Due Date**  Entrance/Book/Insurance Fees $235 08/17/2020-  Entrance/Book/Insurance Fees $250 (After 8/2020)   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  | Entrance/Book/Insurance Fees $100 02/14/21  Entrance/Book/Insurance Fees $125 (After 2/14)  August Tuition $235 08/17/2020  September Tuition $235 09/01/2020  October Tuition $235 10/01/2020  November Tuition $235 11/01/2020  December Tuition $235 12/01/2020  January Tuition $235 01/01/2021  February Tuition $235 02/01/2021  March Tuition $235 03/01/2021  April Tuition $235 04/01/2021  May Tuition $235 05/01/2021  **Entrance/Book/Insurance Fee Refund:**  There will be no refund on entrance/book/insurance fees. The full registration fee and book fee will be charged, no matter when enrollment takes place.  **Delinquent Accounts:**  All student accounts are to be kept current. **Tuition payment is due by the 1st day of each month.** Tuition is due monthly, paid in ten payments August through May.  Tuition payments are due on the 1st of the month.  **If your payment is received on/or before to the 5th of the month, you may deduct $5.**  An account will be considered delinquent after the 5th of the month and will receive a $15.00 late fee. If payment plus late fee has not been received by the Treasurer by the 5th, or a telephone call has not been received with acceptable payment arrangements, a form letter will be sent out reminding you of the balance due and the procedures that must follow as outlined in the Student Handbook. Any student whose account is 30 days past due may be asked to withdraw from school because of non-payment unless suitable arrangements are made and approved by the School Board.  *Powell Valley Christian School admits students of any race, color, religion, ethnic background, country of origin or gender; proffers all the rights, privileges, programs and activities generally available to students; and makes no discrimination on the basis of race, color, religion, ethnic background, country of origin or gender in administration of education policies, application for admission, scholarship programs, and athletic or extracurricular programs.*  Annual Registration/Books/Insurance Fee\*       $335.00 per year  Tuition $2,350.00 per year  Total per student              **$**2,685.00 per year  \*$235 of the registration fees are due at time of registration and are non-refundable and $100.00 is due in February and are non-refundable.  **Family Discounts** In order to assist parents having more than one child enrolled here at Powell Valley Christian School, the following monthly and yearly discounts are made for each child at Powell Valley Christian School:  1st Student 2nd Student 3rd Student 4th Student +  Full Price 10% discount 20 % discount 30% discount  $235.00 monthly $211.50 monthly $188.00 monthly $164.50 monthly  $2,350.00 yearly $2,115.00 yearly $1,880.00 yearly $1,645.00 yearly    Tuition is due monthly, paid in ten payments August through May.  Tuition payments are due on the 1st of the month.  If your payment is received on/or before to the 5th of the month, you may deduct $5 (**\*\*** no discount for Virginia Tax Scholarship tuition).  If you pay after the 5th of the month, a $15 late fee will be added.  If we deduct $5 if payment is received by the 5th of the month, you could save $50.00/$60.00 a year.  *Powell Valley Christian School*  *187 Stairway Drive*  *Dryden, VA 24243*  *Phone & Fax (276) 523-0464*  *powell22.adentistschoolconnect.org* FINANCIAL AGREEMENT FOR SCHOOL YEAR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Our Powell Valley Christian School is operated on our monthly tuition funds received  From our dedicated parents, and from funds donated by the Powell Valley Seventh-day  Adventist Church. All funds are used to pay the salaries of your dedicated teachers and for the operation of our school program. Without these necessary funds we would be  unable to operate our beloved school.  There will be no refund on **entrance/book** fees. The full registration and book fee will be charged, no matter when enrollment takes place.  Tuition payments are due by the 1st of each month.  Delinquent Accounts  All student accounts are to be kept current. An account will be considered delinquent after the 5th of the month and will receive a $15.00 late fee. If payment plus late fee has not been received by the Treasurer by the 5th, or a telephone call has not been received with acceptable payment arrangements, a form letter will be sent out reminding you of the balance due and the procedures that must follow as outlined in the Student Handbook. Any student whose account is 30 days past due may be asked to withdraw from school because of non-payment unless suitable arrangements are made and approved by the School Board.  The account for the previous school year must be settled before a student is permitted to re-enroll. Any delinquent accounts of family members who attend Powell Valley Christian School must be settled before another student from the same family will be admitted.  It will be the policy of the schools within the Columbia Union Conference of SDA to withhold transcripts of academic credit until student accounts are paid or until satisfactory financial arrangements have been made.  **-THEREFORE-**  As a parent or guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Student), I promise to pay the Entrance Fee and the Monthly Tuition Fee **promptly** as stated in our Powell Valley Christian School Handbook.  Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Parent or Guardian)  *Powell Valley Christian School*  *187 Stairway Drive*  *Dryden, VA 24243*  *Phone & Fax (276) 523-0464*  *powell22.adentistschoolconnect.org*      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous School’s Name    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous School’s Address    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Previous School’s Phone Number    Dear Sir or Madam:    This is a request for all transcripts/files you have for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Please send them to me as soon as possible. I would appreciate your sending all evaluative materials that apply:     1. All student records 2. Most recent IEP 3. Discipline Records 4. Grades/standardized test scores 5. Medical information 6. Copy of birth certificate and social security card 7. Any other materials pertinent to better understand this student’s academic performance.     You may mail records to the above address or email to johnniea@pcsda.org.  Please do not hesitate to call me at (276) 202-7747 if you have questions or concerns.    Sincerely,       |  |  |  | | --- | --- | --- | | Johnnie Blanton |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ | | Head Teacher |  | Parent’s Signature Date |     Rev 07-27-2020 |  PVCS 2020/2021 School Calendar **August 2 –** Yard Sale 8:00 a.m. – 2:00 p.m.  **August 9** – Yard Sale 8:00 a.m. – 2:00 p.m.  **August 17** – School Starts (Registration 8:00 – 10:00 a.m.)  **September 3** – Principal Meeting  **September 7** – Labor Day (Holiday – no school)  **September 21 – 25** – MAP Assessment Test Week  **October 15** – Principal Meeting  **October 16** – End of 1st Quarter (43 days)  **October 23** – Parent-Teacher Conference  **October 24** – Fall Festival starting at 5:30  **November 25** – Thanksgiving Break – 25 – 29 (Half day on Nov. 24, 4 hr. day)  **November 30** – School Resumes  **December 5** – Silent Auction at 5:30 pm. Spaghetti Supper with dessert and drinks: Adults $6.00 and kids $4.00.  **December 17** – Christmas Play 7:00 p.m. at the PV SDA Church  **December 18** – End of 2nd Quarter (42 days)  **December 18** – Christmas Break – Dec. 18 – Jan. 3 (Half day on Dec. 18, 4 hr. day)  **January 3** – School Resumes  **January 14** – Principal Meeting  **January 18** – Martin Luther King Jr., Birthday (Holiday – no school)  **February 15 –** President’s Day (Holiday – no school)  **March 12** – End of 3rd Quarter (48 days)  **March 14 – 20** – Spring Break (Half day on Mar. 12, 4 hr. day)  **March 22** – School Resumes  **March 26** – Parent-Teacher Conference  **April 15** – Principal’s Meeting  **May 31** – Memorial Day (Holiday – no school)  **May 27** – Awards day at PV SDA Church 11:00 a.m.  **June 4** – Last Day of School (52 days) | |
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