



## Welcome to Dahlgren School!!

This is your registration packet. Please complete and return, with the items indicated below, prior to the first day of attendance!

November 13, 2007

Dear Sponsor,

Welcome to the NY/VA DDESS schools! Here at Dahlgren School we strive to provide exemplary educational programs that inspire and prepare each student for SUCCESS in a global environment. Please help us by accurately completing the attached registration packet and returning it to our school.

Included in this packet is a Registration Form (DoDEA Form 600). Please ensure you're your child's social security number is entered correctly and that the form is signed by the active duty sponsor. If the sponsor is deployed, it may be signed by his or her spouse with a Power of Attorney (a copy will need to be submitted with the documents). If this is not possible, please ask the school registrar for further assistance.

In order to complete registration so that your child may begin school, you will need to provide the following information:

- a. A **certified birth certificate** from the Department of Vital Statistics of the state of birth. The certificate must include the parent's names and cannot be a pocket card or hospital/congratulatory certificate. A copy of the certificate will be retained.
- b. If the sponsor is not listed on the birth certificate as a biological parent, the child's dependency and custody determination must be documented before enrollment is approved. Please contact the Registrar for a list of required documents.
- c. The child's **social security card**. This document will be copied and retained.
- d. The sponsor's **current military orders**. Orders dated 36 months prior to the beginning of next school year will require an amendment, updated orders or the registrar can provide a form to be completed by the sponsor's unit.
- e. Documentation of the sponsor's **housing assignment in permanent quarters**, either by a housing letter, Housing Assignment Voucher, or the completed front page of the RCI lease agreement or a 90/180-day letter from the appropriate Housing office. The document must list the child as a dependent with authorization to live in housing. **No child will be permitted to start school without this documentation.**

Thank you for your cooperation. If you have any further questions or difficulties obtaining these documents, please contact the Registrar at 540-653-8822 We look forward to serving your child in our school this year!

Steve Hovanic, Principal-Dahlgren School

# CODE DIRECTORIES

Please use the codes below when completing the attached registration packet

**The items below must be provided prior to the child's first day of attendance:**

**The items below must be provided prior to the child's first day of attendance:**

Birth Certificate

Copy of Social Security Card

Copy of Orders

Immunization Card

Virginia Physical  
(or date scheduled)

Medication form  
(if applicable)

Housing Form

School Records  
(or complete school info)

Confidential Records

Custody Papers (If applicable)

Biological Parent/Loco Parentis  
Form (If applicable)

[ K ]	Employee Type	[ O ]	Entry/Status Codes
1A	Army	NEW	Pre-K
1B	Navy	DODA	From DoDDS
1C	Marines	NEW	New to DoDEA Schools
1D	Air Force	FOR	From Foreign School
1E	Coast Guard	HOME	From Home Schooling
2D	Foreign Service	HOST	From Host Nation School
4B	Foreign National	PRIV	From Private School
4C	Other US	DDES	From Another DDESS School
4D	Other Foreign Nat	PUBL	From US Public School
		OTH	From Other

An "Emergency Authorization for Medical Care/Treatment", a "Parent/Student Handbook", and an Internet Acceptable Use Policy Form will be sent home with your child on the first day of school. Each of these must be signed by the parent (and child-Internet and Handbook), and returned to the classroom teacher.

If you are enrolling after the first day of school, **please** make sure that you are given or ask for these forms as well as your child may not use the computers, take RC quizzes, or go on field trips without them.

**DEPARTMENT OF DEFENSE EDUCATION ACTIVITY  
STUDENT REGISTRATION**

**INSTRUCTIONS**

1. Completed by Sponsor/Parent/Guardian
2. Print (Ink) or type all entries.
3. Leave shaded areas blank.
4. See supplemental sheet for assistance.

**PRIVACY ACT STATEMENT**

**AUTHORITY:** 10 USC 2164, 20 USC 921

**PRINCIPAL PURPOSE(S):** Required for enrollment of dependents into DoDEA Schools. Provides record of student and sponsor demographic data used in the administration of school programs. Provides emergency contact, pertinent medical and other vital information.

**ROUTINE USE(S):** Data is collected and entered into the automated School Information Management System for use by DoDEA personnel in providing educational and management programs. Release of student information to non-DoDEA personnel is restricted to U.S. Government personnel and other authorized individuals as approved by DoDEA. Sponsor information may be released to other schools, colleges, and prospective employers as part of the individual student record.

**DISCLOSURE:** Voluntary. Disclosure of the Social Security Number will expedite the registration process.

**SECTION I – STUDENT INFORMATION**

1a. Student's SSN#:		b. Student Legal Name (Last, First, Middle)			c. Preferred Name	
d. Gender	M    F	e. Home Phone		f.	g. Student Grade	
h. Birth Date	i. Field Trip Permission Y            N		j. Sponsor Relationship		k. Employer Type Code 1a: Army 1b: Navy 1c:Marines 1d: Air Force 1e: Coast Guard	
l. Citizenship (Country)		m. Home Language Survey Completed    Y    N		n. Computer/Internet Permission    Y    N		o. Entry Status Code
p. Student Email Address				q. Previous DoDEA Student ?    Y    N		r. Local Use

**SECTION II – SPONSOR INFORMATION**

4. Sponsor's Name (Last, First, Middle Initial)		5. Sponsor SSN#	6. Pay/Civ Grade	7. Title / Rank
8. Organization (AEGIS/JWAC etc...)		9. Building number	10. Duty Phone	11. Rotation Date
12. Spouse's Name (Last, First, Mid.Initial)		13. Spouse's Title	14. Spouse's Employer	15. Work Phone
16. . Physical Address (Street, City, State, Zip Code) Please include the "Court" if in the new housing			17 Mailing Address    (If different from Physical)	
18. Sponsor Cell Phone	19. Spouse Cell Phone	20. Email Address: Sponsor		
21. Pager Number	22. Reserved	23. Email Address: Spouse		

**SECTION III – LOCAL EMERGENCY CONTACT INFORMATION**

**NOTE: Must live within a 30 minute drive of Dahlgren School**

24a. Emergency Contact Name (Not Sponsor or Spouse)		24b. Contact Duty Phone	24c. Contact Home Phone
24d. Emergency Contact Address (During Day)		24e. Doctor's Name (If not Military Clinic)	24f. Doctor's Phone Number
25a. Emergency Contact 2 Name		25b. Contact 2 Duty Phone (Optional)	25c. Contact 2 Home Phone
25d. Emergency Contact 2 Address		25e. Local Use	

**SECTION V – CONSENT and SCHOOL USE INFORMATION**

I understand that I have the right to review my child(ren)'s records and that a copy of the school and health records will be released to the next school (exclusive of colleges and universities) he/she/they attend(s) without further approval.		34. First Day Student Starts School (MMDDYYYY)	35. DoDAAC Y N
I give permission for my child(ren) to receive first aid at school and any emergency treatment considered necessary with the following exceptions noted below.		36. School Name	
I verify the information is correct or has been corrected.		37. Orders on File / Verified	
27. Exceptions (If none, enter NONE)		38. Birth Date Verified	
		39. Reserved	
28. Signature of Parent Guardian	29. Date (MMDDYYYY)	40. Registrar's Initials	41. Date (MMDDYYYY)
30. Reserved	31. Reserved	42. Reserved	
32. Local Use	33. Local Use	43. Local Use	

**BLANKET PERMISSION FORM**

This is a "blanket" permission form which covers specific areas and is to be signed at the time of registration. Please initial each area indicating that you have read them. Your signature at the bottom of the form grants permission for your child to participate in these events. If there are exceptions, please note them in the appropriate box. Your child will then only participate within the parameters of your exceptions.

- Field Trips:** Throughout the coming school year the students of the NY/VA Schools will be taking one-day field trips to points of interest in the area. Parents will be given prior notice, which will include destination, purpose and cost to the child. ***If you do not wish your child to participate in the event, the teacher must be notified at least two days prior to the event so that arrangements can be made for student coverage.*** \_\_\_\_\_  
(Initial Here)
- Videotaping in the School:** During the school year, certain events will be videotaped for school use and display. Your signature grants permission for your child to participate in and be recorded in these school activities. \_\_\_\_\_  
(Initial Here)
- Emergency Phone Calls:** During the school year there may be times when students will be dismissed early. Your signature below grants permission for your home/work/or emergency contact's phone number to be provided to school aides, class "parent", or emergency volunteer personnel who will be charged with notifying parents. \_\_\_\_\_  
(Initial Here)
- Photographs:** There are times, other than regular portrait sittings, when pictures of your child may be taken. Please indicate to what extent these pictures may be used. *(check all that apply)*  
 Pictures of my child  may  may not be used in school publications. (Tiger Beat/Tigers Ink/displays within the school building)  
 Pictures of my child  may  may not be used in outside publications (ie: Bullett/Freelance Star)  
 with name  without name  only in a group-with name  only in a group-without name  
 No pictures taken of my child may be used in any publication at any time. \_\_\_\_\_  
(Initial Here)

I have read the above blanket permission form and note the following exceptions:	
	(Parent/Guardian Signature)

**The items below must be provided prior to the child's first day of attendance:**

- Birth Certificate Copy       Copy of Social Security Card       Copy of Orders   
 Immunization Card       Virginia Physical (or date scheduled)       Housing Form   
 School Records (or complete school info)       Confidential Records   
 Custody Papers (If applicable)       Biological Parent/Loco Parentis Form (If applicable)

**SECTION IV – Previous School Information**

26a. School Name	26b. School Phone  <b>26c. School Fax:</b>
26c. School Address	26d. Special Records/Testing

I, the parent/guardian of \_\_\_\_\_,  
(print name of child enrolling)

who is enrolling in Dahlgren School, and entering into grade: \_\_\_\_\_,

do authorize the release of all school records, (including all standardized testing, report cards, confidential testing, eligibility information, recommendations based on the above, and disciplinary records) for the above named child to:

Dahlgren School  
6117 Sampson Road Suite 120  
Dahlgren VA 22448

(540) 653-8822

Thank you for your prompt response,

\_\_\_\_\_  
(Printed name of Parent/Guardian)                      (Signature of Same)

\_\_\_\_\_  
(Date)

# Department of Defense Education Activity

## Questionnaire for Race/Ethnicity, and Home Language

Completion of this form is required for enrollment in DoDEA schools. The data collected is maintained for "Statistical Use Only" and is protected in accordance with the Privacy Act (93-579), OMB Circular A-108, and DoDEA Directive 5400.11. Unauthorized disclosure of this information constitutes a violation of the Privacy Act and may result in a fine up to \$ 5000.

Race/Ethnicity questions comply with OMB Standards for Maintaining, Collecting, and Presenting Data for Race and Ethnicity, dated 30 October 1997 (62 FR 58782-58790)

STUDENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

PLEASE ANSWER ALL SECTIONS

### ETHNICITY (Mark one)

\_\_\_\_\_ **Hispanic or Latino.** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish Culture or origin, regardless of race.

\_\_\_\_\_ **NOT Hispanic or Latino.**

### RACE (Mark one or more)

\_\_\_\_\_ **A – American Indian or Alaska Native.** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

\_\_\_\_\_ **B – Asian.** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

\_\_\_\_\_ **C – Black or African American.** A person having origins in any of the black racial groups of Africa.

\_\_\_\_\_ **E – White.** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

\_\_\_\_\_ **F – Native Hawaiian or Other Pacific Islander.** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

# DEPARTMENT OF DEFENSE EDUCATION ACTIVITY

## ESL Home Language Questionnaire

**Privacy Act Notice:** Authority to Collect Information: 20 U.S.C. 927(c) and 10 U.S.C. 2164(f), as amended; E.O. 9387; the Privacy Act of 1974, as amended, 5 U.S.C. 552a. **Principal Purpose:** The information will be used within the DoD to determine the services to be provided to a student to assist the child to receive a free appropriate public education. **Disclosure** to the Agency of the information requested on this form is voluntary; but failure to provide all requested information may result in the delay or denial of student services. DoDEA may disclose information requested in this form to other DoD activities and contracted service providers who require the information to deliver educational services to the child and for valid medical, law enforcement or security purposes, or for use in litigation concerning the delivery of student. **Routine Uses:** Disclosure of information contained in this form is authorized outside the DoD in accordance with the "Blanket Routine Uses" described at the beginning of the Office of the Secretary of Defense's compilation of systems of records notices, published at <http://www.defenselink.mil/privacy/notice/osd>.

### THIS FORM IS COMPLETED AT THE TIME OF STUDENT ENROLLMENT

**Child's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Grade:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_

1. What language is commonly spoken in your home?  
\_\_\_\_ English \_\_\_\_ Another Language (Please specify): \_\_\_\_\_
2. Does the child you are registering speak a language other than English? (Excluding foreign languages studied in school.) \_\_\_\_  
No \_\_\_\_ Yes If yes: What language is spoken? \_\_\_\_\_
3. What language did your child use when he/she first began to talk? \_\_\_\_ English \_\_\_\_ Another Language (Please specify): \_\_\_\_\_
4. Has your child attended English speaking schools?  
\_\_\_\_ No \_\_\_\_ Yes If yes: How many years? \_\_\_\_\_
5. What language does your child read and/or write? \_\_\_\_ English \_\_\_\_ Another Language (Please specify): \_\_\_\_\_
6. What language do you most often use when speaking with your child? \_\_\_\_ English \_\_\_\_ Another Language (Please specify): \_\_\_\_\_
7. What language does your child use most often when speaking to you? \_\_\_\_ English \_\_\_\_ Another Language (Please specify): \_\_\_\_\_
8. If your child is cared for by another person on a regular basis, what language is most often used? \_\_\_\_ English \_\_\_\_ Another Language (Please specify): \_\_\_\_\_
9. Do you as a parent need to communicate with the school in a language other than English? \_\_\_\_ No \_\_\_\_ Yes If yes, in what language? \_\_\_\_\_

If based on the results of this questionnaire it is necessary to conduct an evaluation, I understand and give my permission for:

1. My child to be evaluated using a standardized language proficiency test and/or academic achievement test to determine whether he/she is eligible for English as a Second Language (ESL) services. Additional information may be collected from my child's teacher(s) and his/her school records.

**AND**

2. Annual Spring testing to measure my child's academic and English language progress if eligible for services.

I understand that the ESL Teacher will share the results of the assessments with me when testing is completed.

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

\_\_\_\_\_  
Date

**Recommendation** (to be completed by ESL Teacher)

\_\_\_\_ Proficiency Testing \_\_\_\_ Records Review \_\_\_\_ No ESL Services Required

Signature of ESL Teacher: \_\_\_\_\_ Date: \_\_\_\_\_

# AUTHORIZATION for CONSENT TO MEDICAL CARE

Please note: This document must be notarized. The school, the ITT Office, and the Credit Union all have a notary. Please ensure you have your I.D. when coming in to have this form completed.

I, \_\_\_\_\_, a lawful parent/guardian of the following child:  
(Parent/Guardian Name)  
\_\_\_\_\_  
(Name and Grade of Child)

**OPTION 1:**

.....appoint Dahlgren School or representative thereof, to be my lawful attorney-in-fact (agent to perform any and all acts that I might perform if I were present) for the following purpose:

**To authorize transportation and emergency medical , hospital care and treatment, including major surgery, if deemed necessary by a duly licensed physician at any medical or dental facility for the health and well being of my child/children aforesaid.**

I give this authorization in advance of any care of treatment being required in order to provide authority for my said attorney-in-fact to give specific consent to any and all care and treatment that might be necessary in my absence. It is understood that a valid dependent's Identification Card must accompany dependents ten (10) years of age and older at all times.

**OPTION 2:**

.....do **not** authorize NY/VA DDESS- Dahlgren School or any of its employees to authorize the transportation of or for emergency medical treatment for my child. In the event that I, the parent/guardian, cannot be reached, and as such, emergency medical personnel cannot proceed with treatment of my minor child, NY/VA DDESS- Dahlgren School, and all their employees shall be held blameless.

**You must mark one of these options in the boxes provided.  
Have this form signed/notarized and returned to your child's class room teacher.**

*Note:: One parent (Commissioned Officer) can not countersign for another parent within the family. The "Sponsor's" commanding officer must countersign the "Sponsor's" signature if a notary's signature/seal is not available or cannot be obtained. Return of this form is mandatory no matter which option for care is selected.)*

The sponsoring parent is: \_\_\_\_\_

Command: \_\_\_\_\_ ID (SSN#) Number: \_\_\_\_\_

The option chosen from above is:  
 Option 1 (Permission Granted)       Option 2 (Permission Declined)

This Power of Attorney shall become NULL and VOID after: \_\_\_\_\_  
(last day of the school year)

\_\_\_\_\_  
Signature \* **THIS SIGNATURE MUST BE NOTORIZED**) (Date) \_\_\_\_\_ (Parent/Guardian)

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, of the year \_\_\_\_\_ by \_\_\_\_\_, known to me to be the person who executed the foregoing instrument.

\_\_\_\_\_  
(NOTARY PUBLIC)  
STATE OF VIRGINIA  
COUNTY OF KING GEORGE  
My commission expires: \_\_\_\_\_  
or  
\_\_\_\_\_  
(Signature of Commissioned Officer)  
\_\_\_\_\_  
(Name/Rank/Branch/Duty Station)

Seal:

# Dahlgren School Health Form

STUDENT'S NAME: \_\_\_\_\_  
GRADE: \_\_\_\_\_ TEACHER: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Does your child take any daily medication? \_\_\_\_\_yes \_\_\_\_\_no

Name of medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Taken for: \_\_\_\_\_ Taken at (time): \_\_\_\_\_

Name of medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Taken for: \_\_\_\_\_ Taken at (time): \_\_\_\_\_

Is your child a member of the EFM Program? \_\_\_\_\_ yes \_\_\_\_\_ no

Does your child have any allergies? \_\_\_\_\_yes \_\_\_\_\_no

If yes, please list here: \_\_\_\_\_

Does your child carry or require an "Epi-Pen"? \_\_\_\_\_ yes \_\_\_\_\_no

Has your child been hospitalized for any reason since birth? \_\_\_\_\_ yes \_\_\_\_\_no

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

## Please check and explain all items below that apply to your child:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> ASTHMA            | <input type="checkbox"/> DIABETES               | <input type="checkbox"/> SEIZURE DISORDER |
| <input type="checkbox"/> ALLERGY           | <input type="checkbox"/> NEUROMUSCULAR          | (date of last event)                      |
| <input type="checkbox"/> BIRTH INJURY      | <input type="checkbox"/> JOINTS/BONES           | _____                                     |
| <input type="checkbox"/> BEE STING ALLERGY | <input type="checkbox"/> REPEATED SINUSITIS     | <input type="checkbox"/> ADD/ADHD         |
| (reaction): _____                          | <input type="checkbox"/> REPEATED EAR INFECTION | Medication: ___ yes                       |
| <input type="checkbox"/> CHICKEN POX       | <input type="checkbox"/> VISION PROBLEMS        | _____ no                                  |
| (date) : _____                             | <input type="checkbox"/> GLASSES                | If yes: _____                             |
| <input type="checkbox"/> HEART _____       | <input type="checkbox"/> HEARING PROBLEMS       | (name of medication)                      |
| <input type="checkbox"/> KIDNEY INFECTION  | <input type="checkbox"/> HEARING AID(S)         |   |

**Does this child have any other health condition that may affect schoolwork, attendance or school activities?**

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

**Is there anything more about this child's health that you think is important for us to know?**

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

## MEDICATION AT SCHOOL

DoDEA policy does not permit us to give your child medication at school unless it is in the original labeled container with the physician's instructions. Written permission and instructions must be obtained *before* your child can be administered any medications. A **MEDICATION DURING SCHOOL HOURS, PHYSICIAN/PARENT SIGNATURES/HOLD HARMLESS PERMISSION FORM JULY 2004 H.3.2 & H.3.3** (attached) and Health Plan must be completed prior to any form of medication being administered. Over-the-counter medication must also be labeled with your physician's instructions.

Dahlgren School does not have a medical clinic or nurse in the school. Inhalers, prescribed for asthma or cough, may be kept with the child at the parent's discretion under the above guidelines. Dahlgren personnel are not responsible for independent administration or permission for use of any medication, or for determining its need except as outlined, in writing, by the parent and/or physician.

Dahlgren School does not maintain a stock of any medication for administering to the students-not even Tylenol. If your child requires medication, please ensure that you have completed the appropriate forms which are available in the office.

\_\_\_\_\_  
(Signature of Parent/Guardian)

\_\_\_\_\_  
(Date)

## AUTHORIZATION FOR EMERGENCY MEDICAL CARE

*An Emergency Authorization Form will be sent home separately from this enrollment package. It must be notarized and returned to the school, and will be maintained in the office.*

(COMPLETE THIS FORM ONLY IN THE EVENT THAT YOUR CHILD WILL NEED MEDICATION DURING SCHOOL HOURS)

Department of Defense Education Activity HOLD HARMLESS LETTER  
(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

**PRIVACY ACT STATEMENT**

AUTHORITY: 44 USC 3101. PRINCIPAL PURPOSES: (1) To provide necessary information to authorized individuals to assist them in their administering of medication to your child in accordance with your instructions and the instructions of your child's physician; (2) To provide written assurance to said authorized individuals that they will not be held responsible for any harm or injury suffered as a result of the administering of medication in accordance with your instructions and the instructions of your child's physician. ROUTINE USES: This form will be included in your child's school health record and will not be released outside DOD channels. DISCLOSURE: Voluntary. The information requested on this form is needed to insure safe

We, the parents/guardians of \_\_\_\_\_, wish to advise you that he/she is under the care of

Dr. \_\_\_\_\_ for \_\_\_\_\_ and that the physician has furnished medication together with written instructions for administering the medication to alleviate this condition. The medication, physician's instructions, and times for administering the medication are as follows  
**(one medication per form):**

**PHYSICIAN'S INSTRUCTIONS TO SCHOOL PERSONNEL**

To be completed by physician:

Due to the nature of the medication and/or the child's condition, it is necessary that the medication listed below be administered during school hours.

Student's Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

School: \_\_\_\_\_

Diagnosis/Indication for Medication Administration: \_\_\_\_\_ Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Time: \_\_\_\_\_ Route: \_\_\_\_\_

Duration: \_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

Precautions/Restrictions: \_\_\_\_\_

Other Medications Taken: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Physician**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Clinic:**

\_\_\_\_\_  
**Phone**

To be completed by parent/guardian:

I am delivering to you the medication and physician's written instructions and request this medication be given to my child in accordance with the above instructions. I fully understand that you are under no obligation whatsoever to administer the medication but will only be doing so as my agent acting on my behalf specifically and solely for this purpose.

I agree to hold you, the school, its offices, agents, and employees harmless in administering the medication. I further agree to notify you promptly when it is no longer necessary to administer this medication.

I hereby give my permission for \_\_\_\_\_ to receive, from the school nurse and/or other trained school personnel, the above prescription at school as ordered. I understand that it is my responsibility to furnish the school with this medication. I give permission for the school nurse and health care providers at the medical treatment facility to exchange information about my child, the diagnosis for which this medication is prescribed, and my child's response to the medication.

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**

Parent daytime phone number #1 \_\_\_\_\_, #2 \_\_\_\_\_, #3 \_\_\_\_\_

Parent e-mail address \_\_\_\_\_

Home address \_\_\_\_\_

NOTE: The prescription medication must be brought to school in the original container, properly labeled by the pharmacy or physician, stating the name of the student, the medication, the dosage, and current date. The medication will remain at school for the duration of the prescription. The school is not responsible for renewing medications.

## Confirmation of Dependent Status for School Enrollment

This letter is required to determine the eligibility status for dependents of the Sponsor listed below and is **used in lieu of assignment orders**. This form should only be used if a copy of original orders is not available. It is to be verified and signed by the Unit Personnel Officer. Failure to provide this information (or a current copy of orders listing dependent(s)) may result in the dependent (s) being denied enrollment or dis-enrolled from the Department of Defense Domestic Dependent Elementary and Secondary Schools (DDESS).

Sponsor \_\_\_\_\_ SSN \_\_\_\_\_ Rank \_\_\_\_\_

Unit of Assignment \_\_\_\_\_

Assignment Orders Date and Issuing Headquarters \_\_\_\_\_

Date of Tour Conclusion Per Above Orders \_\_\_\_\_

**Dependent Children:** The following dependent child(ren), although not listed on the above cited orders, is/are authorized dependent(s) of the sponsor listed above. State reason why child(ren) are not listed and documentation used to verify that the child/ren is/are a legal dependent(s).

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Explanation: \_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Explanation: \_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Explanation: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Requesting Sponsor's Signature  
Signature

\_\_\_\_\_  
Personnel Officer's Printed Name and

\_\_\_\_\_  
Sponsor's Duty Phone Number

\_\_\_\_\_  
Personnel Officer's Duty Phone Number

# STATEMENT OF FACT BY BIOLOGICAL PARENT

This document is to be completed only if:

A: biological parents of the child were **never married** to each other **and** no divorce or other court-ordered custody documentation exists

B: the sponsoring parent of the child is not the biological parent of the child and has no legal custody of the enrolling child. (step parent, no adoption or legal custody papers signed)

Regarding: Enrollment in School, Stepchild of \_\_\_\_\_  
Printed Name of Active Duty Sponsor

To Whom It May Concern:

I, \_\_\_\_\_, the biological parent of  
Printed name of Parent

\_\_\_\_\_  
Printed name of student Grade: \_\_\_\_\_

Hereby confirm **ALL** of the following statements to be true and accurate:

- I was never married to the biological father/mother of the above-named child **or**;
- that I am the primary custodian of the child/ren named above **and**;
- declare that there are no court ordered documents on file or pending action concerning legal custody of my child/ren named above.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

## ***In Loco Parentis Affidavit***

I, \_\_\_\_\_ (name of sponsor) swear that \_\_\_\_\_ (name(s) of child) are residing in my home, as approved by the installation housing office (if living on base, only). I stand *in loco parentis* to this child(ren) and, as such, make decisions concerning their education. I further swear that I contribute at least one half of their support.

\_\_\_\_\_  
Printed Name of Sponsor

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**From: The Office of the Principal, Dahlgren School  
2116 Sampson Road STE 120  
Dahlgren VA 22448  
540-653-8822**

**SUBJECT: Immunization Requirement Additions**

**Dear Parents,**

**Beginning School Year 2006-07, DoDEA students are required to meet additional immunization requirements that are not noted on the Virginia School Physical. Please consult your child's physician for information that is applicable for your child(ren).**

**You are being provided the new DoDEA Immunization Form 2942.0-M-F1, April 2006 that includes the additional immunization requirements. These additional immunizations are not annotated on the regular Virginia School Physical form. It will not be necessary for your medical provider to list all of the immunizations if previously submitted to DoDEA on that form.**

**The immunization requirements for enrollment in DoDEA schools are determined by the military. The guidelines for military dependent children follow the guidelines from the Center for Disease Control (CDC) and are based upon recommendations from the Advisory Committee on Immunization Practices (ACIP). These are minimum requirements. Additional requirements may be determined by the military medical commands based upon location and need. If a vaccine is not available, DoDEA may grant a temporary waiver for that immunization.**

**If you have any questions or concerns, please feel free to call the office.**

**Signed,**

**Steve Hovanic, Principal Dahlgren School**

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY  
IMMUNIZATION REQUIREMENTS

PRIVACY ACT STATEMENT

**AUTHORITY:** 10 U.S.C. 113, 126, 2164 and 20 U.S.C. 921-932; E.O 9387; the Privacy Act of 1974, as amended, 5 U.S.C. 552a.

**PRINCIPAL PURPOSE:** The information may be used within the Department of Defense (DoD) to determine what immunizations have been administered for purposes of determining enrollment eligibility and for use in preserving school health.

**ROUTINES USE(S):** The Department of Defense Education Activity (DoDEA) may release information without prior consent with the DoD when needed to perform an official DoD duty, in accordance with 5 U.S.C. 552a(b). In addition, in accordance with 5 U.S.C. 552a(b)(3), information contained therein may be disclosed outside the DoD as a routine use pursuant to "Blanket Routine Uses," as published at <http://www.defenselink.mil/privacy/notice/osd>, for example, for valid medical, law enforcement or security purposes, or for use in litigation involving the DoD.

**DISCLOSURE:** Disclosure to the Agency of the information requested on this form is voluntary; but failure to provide all requested information may result in the delay or denial of student services.

Students who enroll in DoDEA schools MUST meet specific immunization requirements. These requirements, displayed below, represent the minimum requirement and do not necessarily reflect the optimal immunization status for a student. This copy of the DoDEA Immunization Requirements is provided to parents for informational purposes. This form does not need to be completed by medical authority. However, some type of medical proof of immunization must be completed by medical authority and provided to school officials at the time of initial registration. This form may be used by medical officials if so desired. If this form is used by medical officials, page 4 must be completed.

STUDENT: \_\_\_\_\_

Date of Birth (MM/DD/YY): \_\_\_\_\_

IMMUNIZATION	Dose Number	Name of Vaccine	Date Immunized	<u>MINIMUM</u> DoD REQUIREMENTS *
Diphtheria, Tetanus, Pertussis e.g., DTP, DtaP, DTwP, DT, DtaP-Hib, DtaP-HepB-IPV, Tdap,Td	#1			Four (4) doses. <b>At least one dose must be administered <u>after</u> the 4<sup>th</sup> birthday.</b>  *ACIP Recommendation: <ul style="list-style-type: none"> <li>• <b>The usual schedule is a primary series of 4 doses at 2m, 4m, 6m, and 15-18m of age.</b></li> <li>• <b>If the fourth dose of DT, DTP or DTaP is administered before the fourth birthday, a booster (fifth) dose is recommended at 4–6 years of age (5<sup>a</sup>).</b></li> </ul> Td or Tdap booster doses: <b>A single Tdap booster dose is recommended for children 11-12 years old, if 5 years elapsed since the last dose; then boost every 10 years with Td (5<sup>b</sup>).</b>
	#2			
	#3			
	#4			
	#5 <sup>a</sup>			
	#5 <sup>b</sup>			
Hepatitis A e.g., HepA	#1			Two (2) doses. ACIP Recommendation: <ul style="list-style-type: none"> <li>• <b>HepA is recommended for all children at 1 year of age.</b></li> <li>• <b>The two doses in the series should be administered at least 6 months apart.</b></li> </ul>
	#2			

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY  
IMMUNIZATION REQUIREMENTS

IMMUNIZATION	Dose Number	Name of Vaccine	Date Immunized	<u>MINIMUM</u> DoD REQUIREMENTS *
Hepatitis B e.g., HepB, Hib-HepB, DTaP-HepB-IPV	#1			Three (3) doses. ACIP Recommendation: <ul style="list-style-type: none"> <li>• The standard schedule is 0, 1 and 6 months.</li> <li>• The first dose is recommended shortly after birth, with the second dose administered at age 1 to 2 months. The third dose should be administered at age <math>\geq</math> 24 weeks.</li> <li>• Merck's Recombivax-HB brand of HepB vaccine can be given as a 2-dose series for adolescents 11 to 15 years of age.</li> </ul> Catch-up schedule: <ul style="list-style-type: none"> <li>• 3-dose series may be started at any age.</li> <li>• Minimum spacing for children and teens: 4 weeks between dose 1 and dose 2, and 8 weeks between dose 2 and dose 3.</li> </ul>
	#2			
	#3			
Haemophilus influenzae type b e.g., Hib, Hib-HepB, DtaP-Hib	#1			Two (2) to four (4) doses. ACIP Recommendation: <ul style="list-style-type: none"> <li>• Primary immunization occurs at 2m, 4m, 6m, and 12m to 15m (booster dose).</li> <li>• For Merck's PedvaxHIB brand of Hib vaccine, 3 doses are needed (2, 4, and 12-15m).</li> </ul> Catch-up schedule: <ul style="list-style-type: none"> <li>• If dose 1 is given at 12-14m, give a booster dose 8 weeks later.</li> <li>• Unvaccinated children from the ages of 15m up to 5 years need only 1 dose.</li> </ul> <b>Hib is not routinely given to children 5 years old and older.</b>
	#2			
	#3			
	#4			
Polio e.g., IPV, DTaP-HepB-IPV Note: Oral Polio Vaccine (OPV) counts for immunization requirements, but is no longer distributed in the U.S.	#1			Three (3) doses. <b>At least one dose must be administered <u>after</u> the 4<sup>th</sup> birthday.</b> ACIP Recommendation: <ul style="list-style-type: none"> <li>• Usual schedule is a primary series of 4 doses at 2m, 4m, 6-18m, and 4-6 years of age.</li> <li>• All doses should be separated by at least 4 weeks.</li> <li>• If dose 3 is given after the 4<sup>th</sup> birthday, dose 4 is not needed.</li> </ul>
	#2			
	#3			
	#4			
Meningococcal				ACIP Recommendation: <ul style="list-style-type: none"> <li>• Meningococcal vaccine (MCV4). Meningococcal conjugate vaccine (MCV4) should be given to all children at the 11–12 year old visit as well as to unvaccinated adolescents at high school entry (15 years of age). Other adolescents who wish to decrease their risk for meningococcal disease may also be vaccinated.</li> <li>• All college freshmen living in dormitories should also be vaccinated, preferably with MCV4, although meningococcal polysaccharide vaccine (MPSV4) is an acceptable alternative.</li> <li>• Vaccination against invasive meningococcal disease is recommended for children and adolescents aged <math>\geq</math> 2 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high risk groups (see <i>MMWR</i> 2005;54 [RR-7]:1-21); use MPSV4 for children aged 2–10 years and MCV4 for older children, although MPSV4 is an acceptable alternative.</li> </ul>

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY  
IMMUNIZATION REQUIREMENTS

IMMUNIZATION	Dose Number	Name of Vaccine	Date Immunized	<u>MINIMUM</u> DoD REQUIREMENTS *
Measles, Mumps, Rubella e.g., MMR, MMRV	#1			Two (2) doses. ACIP Recommendation: <ul style="list-style-type: none"> <li>• <b>Dose 1 is given at 12-15m of age.</b></li> <li>• <b>Dose 2 is recommended routinely at age 4-6 years, but may be administered at any visit if 4 weeks have elapsed since the first dose and both doses are administered beginning at or after age 12 months.</b></li> <li>• <b>Those who have not previously received the second dose should complete the schedule by age 11-12 years.</b></li> </ul>
	#2			
PPD TB tine/monovac	Date of last test:	No Vaccination Required	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative _____ mm induration	Tuberculosis (TB) testing recommended. <b>Frequency determined by local medical command.</b> If positive, date of chest X-ray: ____/____/____ Chest X-ray Results: _____ Date isoniazid (INH) treatment started: ____/____/____ Date INH treatment completed: ____/____/____
Varicella e.g. Var, MMRV	#1			ACIP Recommendation: <ul style="list-style-type: none"> <li>• <b>Immunize all children age 1 year and older, including adolescents who have not had chickenpox.</b></li> <li>• <b>Susceptible children age 1 year and older receive 1 dose.</b></li> <li>• Susceptible people age 13 and older <b>should receive two (2) doses at least 4 to 8 weeks apart.</b></li> <li>▶ Immunization is NOT required in people with a history of natural disease (chickenpox).</li> </ul>
	#2			
	History of naturally acquired chickenpox	Date:		

Notes

\* **Advisory Committee on Immunization Practices (ACIP).**

<sup>a</sup> **The fifth dose is not required if the fourth dose was given on or after the fourth birthday.**

<sup>b</sup> **Second dose required only in susceptible people 13 years old or older.**

\* **The standard and catch-up pediatric and adolescent immunization schedules adopted by the CDC are posted at [www.dcd.gov/nip/recs/child-schedule-color-print.pdf](http://www.dcd.gov/nip/recs/child-schedule-color-print.pdf) and [www.cdc.gov/nip/recs/adult-schedule.pdf](http://www.cdc.gov/nip/recs/adult-schedule.pdf).**

STUDENT: \_\_\_\_\_

Date of Birth (MM/DD/YY): \_\_\_\_\_

Immunization records for the student named above have been reviewed at \_\_\_\_\_  
Location of Clinic

I certify that the minimum immunization requirements have been completed and/or initiated.

Immunizations are current until \_\_\_\_\_ when immunization(s) is/are due.

\_\_\_\_\_  
Signature and Stamp of Medical Authority

\_\_\_\_\_  
Date

**A request for an immunization waiver for medical reasons must be supported by official documents from a medical authority and provided to the school at the time of registration. I certify that the minimum immunization requirements have been waived.**

Immunization(s): \_\_\_\_\_

Reason: \_\_\_\_\_

Waiver Duration: \_\_\_\_\_  
Signature and Stamp of Medical Authority

\_\_\_\_\_  
Date

Please remove this document, complete the upper portion, and take to your housing office. They will complete the bottom and return it to Dahlgren School. Thank you!

**HOUSING VERIFICATION FORM**

Name of Pupil: \_\_\_\_\_ Grade: \_\_\_\_\_

Teacher: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Child's SSN:: \_\_\_\_\_

Sponsor's Name: \_\_\_\_\_ Rank/Rate: \_\_\_\_\_

Sponsor's SSN: \_\_\_\_\_ Command: \_\_\_\_\_

Command Phone Number: \_\_\_\_\_ Work E-Mail: \_\_\_\_\_

Date Child will first enter Dahlgren School: \_\_\_\_\_

Qualifying home address: \_\_\_\_\_ phone: \_\_\_\_\_  
*(Please indicate unit number and "Court" if applicable)*

**If the family is not in housing at this time-please provide a physical address:**

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

**TO BE COMPLETED BY HOUSING OFFICE OFFICIAL**

1. Date family entered housing: \_\_\_\_\_

Address: \_\_\_\_\_

(If family is not currently in housing, please complete number 2)

2. Estimated date that family will enter housing: \_\_\_\_\_

Waiting list time: (circle one)      90 days      60 days      30 days

*This is to certify that the above information has been verified from official housing and billeting records on file at NSWC, Dahlgren, VA.*

\_\_\_\_\_  
*(Name of Official)*

\_\_\_\_\_  
*(Title)*

\_\_\_\_\_  
*(Date)*