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813 Diligence Drive, Ste. 110
Newport News, VA 23606
(757) 591-4971
http://enterprise.nn.k12.va.us

Dear Families,

Newport News Public Schools is dedicated to the safety and security of our students, staff and guests. This year, the school district has installed a new visitor management system to ensure that individuals visiting and interacting on our school campuses are properly identified and signed in.

Across the school district, the new Raptor Visitor Management System has replaced the computer or paper sign-in sheets. As part of this new system, everyone visiting our school is required to present valid photo identification to the office staff. Accepted forms of identification include:

- Any state-issued driver's license or identification card
- Military ID (active duty or retired)
- Passport

Once the office staff scans the identification provided, Raptor instantly checks the name against registered sex offender registries nationwide. Once the visitor has been cleared and entry is approved, the Raptor system prints a visitor badge with the person's name, photo and destination. The visitor badge must be returned to the main office at the conclusion of the visit.

It is important to note that the Raptor system only scans the visitor's name, date of birth, and photo for comparison with the national database of registered sex offenders. Any additional information is not collected nor stored. The Raptor system is not connected to any other database, such as the Department of Motor Vehicles, the police department, or Department of Justice. Any other information on the ID is not visible or accessible to Raptor users and the data that is screened is not shared or communicated.

This new procedure will be required for all family members and visitors. If the purpose of your visit is to sign out a student prior to dismissal, visit a location on campus, or volunteer in a classroom, you will be required to follow the new procedure.

If you do not have a government-issued form of identification, here are some resources to assist you:

- For a Virginia License or ID card, visit a local DMV office or go to www.dmv.virginia.gov
- For a Military ID card, please go to www.cac.mil/uniformed-services-id-card/

We strive to provide a welcoming and warm environment for our families, students and staff while communicating a culture of safety and security to the community.
Thank you for your understanding and for supporting our efforts to enhance school safety.

ENTERPRISE Eagles
Soaring to Excellence

THINGS YOU SHOULD KNOW ABOUT ENTERPRISE ACADEMY

OUR MISSION: The staff at Enterprise Academy is a caring professional team, which provides a unique educational program dedicated to encourage growth of young individuals. We provide a safe and structured environment in which students can make the choices that will bring positive changes within their lives and will enable them to become contributing members of society and lifelong learners.

- All students are expected to abide by the rules of conduct of Enterprise Academy and the NNPS Rights and Responsibilities handbook pursuant to Virginia Department of Education code: **§ 22.1-279.6**. (enclosed in the enrollment packet)
- Participating students and parents must agree to a ***contract*** that explains expectations; **all** students are expected to follow school procedures and policies
- All students will be checked-in by the security staff prior to reporting to class
- Any student who arrives tardy, after the morning search has ended, must be signed-in by a Parent
- Students attending Enterprise Academy may not attend athletic events or any activities having to do with their zone school or any public school (students are not allowed on other public-school grounds at any time while enrolled at Enterprise Academy without written permission from school district officials)
- Enterprise Academy has a required dress code (included in the enrollment packet)
- Students are expected to complete class assignments, homework, projects, end of the marking period assessments
- A weekly progress report is issued unless there is a holiday or report cards are issued; the report provides information on present performance in academics, work-study habits and attitude & behavior
- Major highlights of the program include a small pupil to teacher ratio **and** a structured schedule
- All instructional courses and grading scale are in alignment with Newport News Public Schools (NNPS) and meet state SOL requirements

ENTERPRISE Eagles
Soaring to Excellence

THINGS YOU SHOULD KNOW ABOUT ENTERPRISE ACADEMY

- The frequency of homework is determined by the classroom teacher in accordance with the policy of NNPS
- Notices of disciplinary action will be given to the student and every effort will be made to notify the Parent by telephone
- Breakfast and lunch are available at **no cost** to the students
- Eligible students are in grades 6 – 12
- Enterprise Academy is a regional program (students attending are from Newport News, Hampton, York County, Poquoson and Williamsburg-James City County)
- All Enterprise Academy staff members can be reached at 757-591-4971 or by email

MAKE-UP WORK POLICY: In order to ensure that the education of your child is not interrupted, it is the responsibility of the parent and child to adhere to the make-up work policy.

1. Contract the main office at 757-591-4971 to request make-up work or student can log-in to CANVAS to keep up-to-date with classwork.
2. Notice of 24 hours is required.
3. Completed work must be returned within five school days.
4. Student will forfeit the grade (s) if work is not picked up or returned within five days.
5. For long term illnesses/absences, work should be picked up and returned every five days.
6. Upon the child's return to school, the parent/student is expected to return the textbooks, resource materials, etc.

ATTENDANCE NOTICE: Parents are expected to contact the school on the day your child is absence at 757-591-4971 ext. 28501. ***A note is required within five days of your child's return to school.***

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 earlier 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 Code_____

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: _____-_____-_____

Hospital Preference: _____

Child's Health Insurance: None☐ FAMIS Plus (Medicaid) ☐ FAMIS☐ Private/Commercial/ Employer Sponsored☐_____

Box 1. Pre-Existing Conditions

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes: Type 1		
Please list **Life Threatening Allergies**:			Diabetes: Type 2		
			Insulin pump		
Allergies (seasonal)			Head injury, concussion		
Asthma or breathing conditions			Hearing conditions or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart conditions		
Behavioral/Psych/ Social conditions			Lead poisoning		
Developmental conditions			Muscle conditions		
Bladder conditions			Seizures		
Bleeding conditions			Sickle Cell Disease (not trait)		
Bowel conditions			Speech conditions		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental Health conditions			Vision conditions		

Describe any other important health-related information about your child (☐ Feeding tube , ☐ Trach , ☐Oxygen support, ☐ Hearing aids, ☐ Dental appliance, ☐ Wheelchair, Hospitalizations, etc.):

Box 2. Medications

List all prescription, emergency, over-the-counter, and herbal medications your child takes regularly (Home/ School):

Medication Name	Dosage	Time Administered (Home/School)	Notes
1.			
2.			
3.			
4.			

Additional Medications (Name, Dose, Time Administered, Notes)

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)			

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 Interpreter: _____Date_____/_____/_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Part II - Certification of Immunization

Check if the student's Immunization Records are attached using a separate form signed by HCP ☐

Section I

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. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box. Please contact your local health department for assistance with foreign vaccine records.

Student Name: **Date of Birth :** / / **Sex:**

Race (Optional): **Ethnicity:** ☐ **Hispanic** ☐ **Non-Hispanic**

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
Diphtheria, Tetanus, Pertussis Vaccine (DTP, DTaP)	1	2	3	4	5
Diphtheria, Tetanus (DT) or Tdap or Td Vaccine (given after 7 years of age)	1	2	3	4	5
Tdap Vaccine booster	1				
Poliomyelitis Vaccine (IPV, OPV)	1	2	3	4	5
Haemophilus influenzae Type b Vaccine (Hib conjugate) only for children <60 months of age	1	2	3	4	
Rotavirus Vaccine (RV) only for children < 8 months of age	1	2	3		
Pneumococcal Vaccine (PCV conjugate) only for children <60 months of age	1	2	3	4	
Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Measles, Mumps, Rubella Vaccine (MMR vaccine)	1	2			
Measles Vaccine (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
Rubella Vaccine	1	2	Serological Confirmation of Rubella Immunity:		
Mumps Vaccine	1	2	Serological Confirmation of Mumps Immunity:		
Hepatitis **B** Vaccine (HBV) ☐ Merck adult formulation used	1	2	3	4	
Hepatitis **A** Vaccine	1	2			
Meningococcal **ACWY** Vaccine	1	2			
Meningococcal **B** Vaccine	1	2	3		
Human Papillomavirus Vaccine (HPV)	1	2	3		
Influenza (Yearly)	1	2	3	4	5
Other	1	2	3	4	5
Other	1	2	3	4	5

Certification of Immunization

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Reference Section III).

Signature of Medical Provider or Health Department Official:_____ **Date (*Mo., Day, Yr.*):** 12 /___/____

Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date. This section must be attached to Part I Health Information (to be filled out and signed by parent).

Student's Name: _____ Date of Birth: |____|____|_____|
Parent or Legal Guardian Name: _____
Parent or Legal Guardian Name: _____
Phone Number: _____

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:[____]; PCV:[_____]; RV:[____]; Measles :[_____];

Mumps:[____]; Rubella :[____]; VAR:[_____]; Men ACWY:[____]; Men B:[____]; Hep A:[_____]; HBV:[____]

This contraindication is permanent: [ ], or temporary [ ] and expected to preclude immunizations until: Date (*Mo., Day, Yr.*): |_____|_____|_____.

Signature of Medical Provider or Health Department Official:_____Date (*Mo., Day, Yr.*):___/___/___

RELIGIOUS EXEMPTION: The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

CONDITIONAL ENROLLMENT: As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on_____.

Signature of Medical Provider or Health Department Official:_____Date (*Mo., Day, Yr.*):|___|___|___|

Section III Requirements

For Minimum Immunization Requirements for Entry into School and Day Care, consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations (Ref. *Code of Virginia* § 32.1-46(a)).
(Requirements are subject to change.)

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

Physical Examination

1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment

	1	2	3		1	2	3		1	2	3	
HEENT				Neurological				Skin				
Lungs				Abdomen				Genital				
Heart				Extremities				Urinary				

Tuberculosis Screening

Check the box that applies:

☐ 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: ☐ Negative ☐ Positive

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 _____

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.

❑ Screened by OAE (Otoacoustic Emissions): ☐ Pass ☐ Referred

	1000	2000	4000
R			
L			

☐ Referred to Audiologist/ENT ☐ **Unable to test – needs rescreen**

☐ Permanent Hearing Loss Previously identified: ☐ Left ☐ Right

☐ Hearing aid or another 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

☐ Problems Identified: Referred for Treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

☐ **Unable to perform**

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::_____

____I**ndividualized 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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Dear Parent/Guardian,

Enterprise Academy offers various activities and incentives throughout the school year. Also, we have various guest speakers, volunteers and mentors that work with the students. The Enterprise Academy students can earn incentives based on their attendance, positive behaviors and or academic improvement. The incentives may involve treats such as chips, sodas, pizza, and ice cream. Any inappropriate behaviors, lack of attendance to school or failing grades may disqualify students from participating in the incentive activities.

Your signature on the form will allow your child to participate in the activities and partake of any food. If you have questions, we can be reached at the telephone number above.

Sincerely,

Enterprise Academy Leadership Team

I give my child, _____ permission to participate in the various activities and incentives as well as working with mentors and volunteers.

Please list any food allergies: _____

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Parent/Guardian Signature Date

Check one:

☐ opt Out of ALL activities
☐ opt Out of Specific Activities
Please Specify: _____

ADDITIONAL INFORMATION

STUDENT NAME _____

1. Name: _____

Phone Number: _____

☐ Probation Officer ☐ Social Worker ☐ Outreach Counselor ☐ In-Home Counselor ☐ Family/Friend

2. Name: _____

Phone Number _____

☐ Probation Officer ☐ Social Worker ☐ Outreach Counselor ☐ In-Home Counselor ☐ Family/Friend

3. Name: _____

Phone Number _____

☐ Probation Officer ☐ Social Worker ☐ Outreach Counselor ☐ In-Home Counselor ☐ Family/Friend

4. Name: _____

Phone Number _____

☐ Probation Officer ☐ Social Worker ☐ Outreach Counselor ☐ In-Home Counselor ☐ Family/Friend

I give permission for the persons named above to speak with my child, get educational records and transport if needed.

_____

Parent Signature