Virginia K-12 Parent Opt-Out Notice

To Whom It May Concern: Please take notice that pursuant to Virginia Statutes ("Va. Code") §§ 22.1-203, 22.1-203.1, 22.1-207, 22.1-270(D), 22.1-270.2; Family Educational Rights and Privacy Act (FERPA); 20 United States Code ("U.S.C.") §1232(h); 34 Code of Federal Regulations ("CFR") 98.4; and the U.S. Supreme Court's decision in *Mahmoud v. Taylor*, No. 24-297, 2025 U.S. LEXIS 2500, 606 U.S. ___(June 27, 2025). Based on these my child shall be exempted for the current school year from the following school instruction and/or activities as indicated by the boxes checked below:

☐ **Material that Relates to Sexual or Religious Beliefs** – Pursuant to the U.S. Supreme Court's decision in *Mahmoud v. Taylor*, No. 24-297, 2025 U.S. LEXIS 2500, 606 U.S.__(June 27, 2025), this serves as written notice that – based on my religious beliefs – my child shall be exempted from exposure to the following: (1) any instruction, instructional activity, lesson, presentation, display, event, school assembly, program, or other audio, visual, or written material that promotes, discusses, or recognizes sexual lifestyles other than that found in the marriage between one man and one woman; and (2) any instruction, instructional activity, lesson, presentation, display, event, school assembly, program, or other audio, visual, or written material that promotes, discusses, or recognizes any gender identity other than that which is synonymous with the biology of one's sex at birth. This exemption applies to any of the aforementioned material, whether that material is in the curriculum or outside of the curriculum and whether that material is in the classroom or outside of the classroom. Furthermore, please notify me at least two (2) weeks in advance if any of the aforementioned material will take place in, be presented in, or be used in any of my child's classes or in my child's school. While I understand that some parents may not object to this type of material being present in or taught at school, I feel strongly that these matters are best discussed at home.

☐ **Reproductive Health & Disease Education** – To the school principal: Pursuant to Va. Code § 22.1-270(D), this serves as written notice that my child shall be exempted from the requirement of a health examination due to my religious beliefs.

☐ **Contraceptive Services** – This serves as written notice that my child is not to be given birth control, condoms, or abortion advice, and shall be excluded from participation in any instruction or discussions on these topics, pursuant to Va. Code §§ 22.1-207.1 and 22.1-207.2, which require parental notification and consent for sex education.

☐ **Health Examinations** – To the health personnel providing health services at my child's school: Pursuant to Va. Code § 22.1-16.8, this serves as written notice that my child shall be exempted from the requirement of a health examination due to my religious beliefs.

☐ **Immunization** – To the _____County Health Department medical director or designee: Pursuant to Va. Code §22.1-271.2, my child is to be exempted from the immunization(s) as indicated below based upon the following: (*check those items which apply*)

☐ The administration of immunizing agents conflicts with my religious tenets or practices. I have completed and attached the Commonwealth of Virginia School Entrance Health Form (signed by my Health Department Official or Medical Provider), as required by Code of Virginia § 22.1-270.

☐ My child's physician – licensed under Title 54.1 of the Code of Virginia – certifies in writing that my child should be permanently exempt from the required immunization(s) for medical reasons, as documented on the appropriate Virginia Department of Health form (e.g., Form MCH 213G). This exemption is provided in accordance with Va. Code § 22.1-271.2(A), which permits medical exemptions when immunization would be detrimental to the child's health. My child's physician supports this conclusion with valid clinical reasoning or medical evidence.

☐ My child's physician – licensed under Title 54.1 of the Code of Virginia – certifies in writing that my child has received all immunizations that are medically indicated at this time and is in the process of completing the remaining required immunizations. This status is documented on the appropriate Virginia Department of Health form (e.g., Form MCH 213G) in accordance with

Va. Code § 22.1-271.2 and related regulations. My child's physician supports this conclusion with valid clinical reasoning or medical evidence.

☐ The Department has determined that, according to recognized standards of medical practice, any required immunization is unnecessary or hazardous.

☐ My child is a student who has transferred into a new school division, and an authorized school official has issued a temporary exemption for up to 30 school days to allow my child to attend class while official immunization records are being obtained. According to Virginia Department of Health guidelines and Va. Code § 22.1-271.2(B), school boards may authorize principals, school nurses, or other designated personnel to grant such temporary enrollment permissions pending documentation.

☐ My child is a student who is 1) experiencing homelessness under the McKinney-Vento Homeless Assistance Act and Va. Code § 22.1-3, and 2) is known to the Virginia Department of Social Services as a child in foster care or receiving child welfare services. As such, my child is entitled to a temporary exemption of up to 30 school days from an authorized school official.

☐ My child is a student who has entered a juvenile detention center or alternative education program, AND an authorized school official has granted a 30-day temporary exemption to permit school attendance while immunization records are located or vaccinations are administered.

The immunization(s) for which my child is exempted are as follows:

☐ All immunizations

☐ List of applicable immunizations

☐ **Virginia Immunization Information System (VIIS)** – To the Virginia Department of Health: This serves as written notice that I decline participation in the Virginia Immunization Information System (VIIS) for my child. Pursuant to Va. Code § 32.1-46.01(C) and 12VAC5-115-130, I understand that participation in VIIS is voluntary, and I have the right to opt out. I am submitting a VIIS Opt-Out Form to the Virginia Department of Health, which may be obtained from the VIIS Program Office at 109 Governor Street, Richmond, VA 23219, or by contacting VIIS directly. As provided by Virginia law and administrative code, my child's immunization records will not be shared through VIIS with other providers, agencies, or entities once the opt-out is processed.

☐ **Dissection (check those items which apply)**

☐ Pursuant to Va. Code § 22.1-200.01, this serves as notice that my child is to be excused from participation in dissection or surgery activities involving nonliving mammals or birds.

☐ Pursuant to Va. Code § 22.1-200.01, this serves as notice that my child is to be excused from performing biological experiments on nonmammalian vertebrates.

☐ Pursuant to Va. Code § 222.1-200.01, this serves as notice that my child is to be excused from engaging in anatomical studies of any animal if an anatomical model is used as an alternative.

☐ Pursuant to Va. Code § 22.1-200.01, this serves as notice that my child is to be excused from engaging in anatomical studies of nonliving nonmammalian vertebrates if no anatomical model is used.

☐ **Pledge of Allegiance** – Pursuant to Va. Code §22.1-202(C), this serves as notice that my child is to be excused from reciting the pledge of allegiance. An excused student need not even stand at attention or put his hand over his or her heart when the pledge of allegiance is read. *Frazier v. Winn,* 535 F.3d 1279 (11th Cir. 2008).

☐ **Private Information –** Pursuant to the Protection of Pupil Rights Amendment ("PPRA") (20 U.S.C. §1232h) and to 34 CFR § 98.1 et seq., absent my written consent, my minor child shall not be required to submit to a U.S.-Department-of-Education-funded-or-administered survey, analysis, or evaluation that reveals information concerning the following things (unless an exception in 20 U.S.C. § 1232h(c)(4) applies):

(1) my or my child's political affiliations or beliefs;

(2) mental or psychological problems of my minor child or his or her family;

(3) sexual behavior or attitudes;

(4) illegal, anti-social, self-incriminating, or demeaning behavior;

(5) critical appraisals of other individuals with whom respondents have close family relationships;

(6) legally recognized privileged or analogous relationships, such as those of lawyers, physicians, and ministers;

(7) my or my child's religious practices, affiliations, or beliefs;

(8) income (other than that required by law to determine eligibility for participation in a program or for receiving financial assistance under such program);

Furthermore, pursuant to the PPRA, my minor child shall not be required to participate in the following U.S.-Department-of-Education-funded-or-administered *activities* without prior notification from the local educational agency (unless an exception in 20 U.S.C. § 1232h(c)(4) applies):

(1) Activities involving the collection, disclosure, or use of personal information for the purpose of marketing or for selling that information (or otherwise providing that information to others for that purpose).

(2) Any nonemergency, invasive physical examination or screening that is:

a. required as a condition of attendance;

b. administered by the school and scheduled by the school in advance; and

c. not necessary to protect the immediate health and safety of the student, or of other students.

The term "invasive physical examination" means any medical examination that involves the exposure of private body parts, or any act during such examination that includes incision, insertion, or injection into the body, but does not include a hearing, vision, or scoliosis screening.

Keep this signed, written notice on file in my child's cumulative folder. This notice supersedes all prior opt-out notices.

Child's Name_____ Grade Level_____ Date_____

Parent/Guardian's Name(s) _____ _____

Parent/Guardian(s) Address _____

Parent/Guardian's Signature(s) _____ _____

Daytime/Evening Phone Number(s) _____ _____

School Name_____ School District _____

Received by (Print Name) _____

Received by (Signature)_____ Date Received _____

Instructions and Information on Using the Virginia Parent Opt-Out Notice

Note: These instructions are designed to assist you as a parent in completing the foregoing notice. These instructions should not be given to the school.

Parents, please be advised that under Virginia Code § 1-240.1, parents possess a fundamental right to determine their children's upbringing, education, and care. Public schools are required to provide parents the opportunity to review instructional materials and establish procedures for opting their children out of lessons containing sexually explicit content, as stipulated in § 22.1-16.8. Parents are encouraged to contact their child's school to inquire about policies for reviewing classroom and library materials, raising concerns regarding instructional content, and requesting alternative assignments. Additionally, Virginia offers private school scholarships to eligible families through the Education Improvement Scholarships Tax Credit (EISTC) program. Staying informed and engaged remains the most effective means of supporting your child's education.

What to Do

THE OPT-OUT NOTICE MUST BE SUBMITTED EVERY YEAR

1) Check each box that applies to your concerns.
2) Make two copies of the completed notice. Then, sign and date each copy in ink.
3) Send the Opt-Out Notice to the school Principal by Certified Mail, Signature Requested (Preferred method). Alternatively, it could be sent by fax or any other method whereby delivery can be confirmed. The principal's signature serves as proof of service. You do not need, nor are you asking for, the district's agreement or authorization. You only need proof that you delivered the Opt-Out Notice to the school.
4) Keep one copy (with the proof of service) for your family and ask that the school keep a copy in your child's school records (the cumulative file).
5) Educate your children to report to you attempts to compel them to participate in instruction or activities from which you have requested them to be opted out.
6) Resubmit a copy of this Opt-Out Notice for each child when you enroll them for the next school year.

Feel free to make copies and share this Virginia Parent Opt-Out Notice with other parents.

The Pacific Justice Institute
www.pacificjustice.org

COMMONWEALTH OF VIRGINIA
CERTIFICATE OF RELIGIOUS EXEMPTION

Name _____ **Birth Date** _____

Student I.D. Number _____

The administration of immunizing agents conflicts with the above-named student's/my religious tenets or practices. I understand, that in the occurrence of an outbreak, potential epidemic or epidemic of a vaccine-preventable disease in my/my child's school, the State Health Commissioner may order my/my child's exclusion from school, for my/my child's own protection, until the danger has passed.

_____ _____

Signature of parent/guardian/student **Date**

I hereby affirm that this affidavit was signed in my presence on

This _____ **Day of** _____

Notary Public Seal

Form CRE-1; Rev. 00/92

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:

☐		

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:**_____

Practice/Clinic Name: _____ **Address:**_____

Phone:_____-_____-_____ **Fax:** _____-_____-_____ **Email:**_____