REGISTRATION CHECKLIST – NEEDED FORMS AND DOCUMENTS

Student's Name: ____

Grade Applying For: ______________   School Year: _____________

Forms in this packet that must be returned before registration is complete include:

☐	Application for Enrollment
☐	Home District Questionnaire
☐	Request for Student Records
☐	Special Education Services Questionnaire
☐	Medication Administration Permission Form
☐	Home Language Survey
☐	Internet/Computer Acceptable Use Policy
☐	Photo Consent/Denial Policy
☐	Student Residency Questionnaire
☐	Health Appraisal Form (front & back)

Records you must provide to the school before registration is complete:

- ✓ Certified copy of birth certificate
- ✓ Copy of child's Social Security card and/or passport/visa/immigration papers
- ✓ Copy of last report card from previous school
- ✓ Immunization record (available from child's pediatrician)
- ✓ Copy Custody and/or Adoption Paperwork (if applicable)

When completed - return this packet to:
A Global Educational Excellence Academy
[Academy Name]
[Address]
P: [Phone Number] F: [Fax Number]
[Academy Site]

Global Educational Excellence

Enrollment Application

Student Information	
Name (Last, First, MI):	Primary Language Spoken by **Student**:
Street Address:	Primary Language Spoken in the Home:
City, State, Zip:	Grade Sought:
Date of Birth: Gender: M | F	Place of Birth:
Social Security #:	Is **student** one of the following? (check one) ☐ A citizen or national of the United States ☐ A lawful Permanent Resident (Alien) A ☐ An Alien authorized to attend public school in the US Alien/Admission #: ______________________
Previous School District:	
Current Grade:	
Current School:	

☐ I certify that the child I am enrolling at the Academy has not been previously expelled or received a long term suspension from school of more than 10 days, nor is expulsion/suspension pending.

☐ The above-named child that I am enrolling has been previously expelled/suspended from a school. I authorize access to all school records and further authorize communication with the school(s) listed below regarding this matter. I understand my child's admission to the Academy will be at the discretion of the Academy Administration and Board of Directors.

Parent Information	
Father's Name (Last, First):	Father's Ethnicity:
Address (if different than child's):	
Employer/Occupation:	Email Address:
Home Phone:	Work/Cell Phone:
Mother's Name (Last, First):	Mother's Ethnicity:
Address (if different than child's):	
Employer/Occupation:	Email Address:
Home Phone:	Work/Cell Phone:

Ethnicity (place appropriate number in box) — Father's Ethnicity: ☐ Mother's Ethnicity: ☐

(1) Hispanic/Latino of any race **(2)** American Indian or Alaska Native **(3)** Asian **(4)** African American
(5) Native Hawaiian/Other Pacific Islander (Having origins in people of Hawaii, Guam, Samoa or other Pacific Isla)
(6) White (Having origins in people of Europe, the Middle East or North Africa) **(7)**Two or more races

With whom does the child live? Mother / Father / Both / Other	Marital Status: Single / Married / Divorced
Is a custody decree in place? Yes / No / Pending	If YES, copy given to school? Yes / No

Student Sibling Information			
Sibling Name:	Enrolled here? Yes / No / Waiting List	Date of Birth:	School currently enrolled in:
Sibling Name:	Enrolled here? Yes / No / Waiting List	Date of Birth:	School currently enrolled in:
Sibling Name:	Enrolled here? Yes / No / Waiting List	Date of Birth:	School currently enrolled in:
Sibling Name:	Enrolled here? Yes / No / Waiting List	Date of Birth:	School currently enrolled in:

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE, TO THE BEST OF MY KNOWLEDGE.

Parent/Guardian Signature____ Date:_____/_____/________

FOR OFFICE USE ONLY

Application Date: __________ Active: __________ Date Records Sent: __________ Graduated: __________
Start Date: __________ Waiting List: __________ Moved/Transfer: __________ Withdrawn: __________

Home District Questionnaire

Parent's Name: ____

Student's Name: ____

Grade: _________________

School district student is coming from:

____

1. Do you feel your home district provided the program necessary to meet your child's academic and social needs, and in an environment that you felt was safe?

   ____

2. Why did you choose to leave your home district?

   ____

3. Were we recommended to you by anyone in your home district? _________

   a. If so, by whom? __________________

4. How did you hear about us?

   ____

Thank you for taking the time to fill out this survey. We know that you child's experience at our academy will be a rewarding one!

REQUEST FOR STUDENT RECORDS

We have just enrolled the following student. Please forward all records, including medical records, social and psychological evaluations, and special education records that would assist us in placing and evaluating this student. Thank you.

Student Information

Student's Full Name: ____

Student's Birth Date: ____/_____/_________ Grade: __________

Previous District Information

School Name: ____

School District: ____

School Address: ____

School Phone Number: ___________________________________

School Fax Number: _____________________________________

Today's Date: ____/_____/_________

Parental Information and Approval

Signature of Parent/Guardian: ____

Address:

____

City: ____ State: _________ Zip: ___________

Telephone: _____________________________ Cell: ______________________

When completed - return this packet to:
A Global Educational Excellence Academy
[Academy Name]
[Address]
P: [Phone Number] F: [Fax Number]
[Website]

SPECIAL EDUCATION SERVICES QUESTIONNAIRE

Student Name: ____

Grade: ____________________ Date: _____/______/__________

1. Have you ever attended an I.E.P.C. (Individualized Educational Planning Committee) meeting where your child's eligibility for Special Education was discussed? (Circle one) YES | NO

   If YES, where and when:

   ____

   ____

2. Is your child currently enrolled in Special Education or has s/he received special education services in the past? (Circle one) YES | NO

   If YES, please describe the serviced received (e.g. resource room, speech, etc):

   ____

   ____

3. My child does not receive special services; but they do have a 504 plan. (Circle one) YES | NO
4. Did your child receive any other special services, such as social work referrals to other sources, counseling, tutoring, etc.? (Circle one) YES | NO
5. If YES, please explain:

   ____

   ____

   ____

   ____

6. If your child has been a part of a Special Education program, do you have a copy of your child's current I.E.P. (Individualized Education Plan)? (Circle one) YES | NO

   If NO, please obtain and provide the I.E.P. to the school before the first day of school.

7. Do you feel your child is a candidate for Special Services? (Circle one) YES | NO

   If YES, please explain: ____

8. Have you ever had discussions with any school personnel regarding your child being tested for academic, behavior, or emotional concerns? (Circle one) YES | NO

   If YES, what was their position: ____

9. When is the best time to contact you by phone? ________________

   At what phone number can you be reached? ____________________________

Parent's Name (Print): ____

Parent's Signature: ____

MEDICATION ADMINISTRATION PERMISSION FORM

Student Name: ____

Date form received by the Academy: _____/_______/___________

Grade: ________ Class #: __________________ Birth Date: _____/_____/________

TO BE COMPLETED BY THE PHYSICIAN			
Name of medication:			
Dosage:			
** Medicine Type (circle one): Tablet / Liquid / Inhaler / Injection / Nebulizer / Other:			
Instructions: ____			
Start Date:	Stop Date:	OR ☐ As Needed (via phone verification)	
Restrictions/Side Effects:			
Storage Requirements:			
Physician Name:		Phone Number:	

****FORM MUST BE SIGNED BY THE PHYSICIAN – See below**

TO BE COMPLETED BY PARENT/GUARDIAN

☐ I request that my child, _______________________________________ receive the above medication at school according to the standard school policy.

☐ I certify that my child, ____ is both capable and responsible, and I am requesting that he/she be allowed to self-administer the above medication at school according to the standard school policy.

REQUIRED SIGNATURES

IMPORTANT NOTE: A physician signature is required regardless of whether the medication is over-the-counter or prescription. So, for example, this would include Tylenol, cold or allergy medicine, etc.

Physician Signature: ____ Date: _____/_____/________

Telephone: __________________________

Parent Signature: ____ Date: _____/_____/________

Relationship (MUST be parent/guardian): ____

Telephone: __________________________

HOME LANGUAGE SURVEY

Name of Student: ____ Age: ________

In order to determine the number of students who speak a language other than English we are requesting the following information:

1. Was the student born in the U.S.? (Circle one) YES | NO

   Country of Birth: ___________________________ Grade: ____________
   If no, what date did the student move to the U.S.? _____________
   Country of birth:___________________________
   ______ Has the student been in the U.S. less than one year

   ______ Has the student been in the U.S. more than one year but less than three years

   ______ Has the student been in the U.S. more than three years

2. Is English the first language that the student learned to speak? (Circle one) YES | NO
   If NO, what is the first language that the student learned to speak? ______________________

3. Is English regularly (most of the time) spoken at home? (Circle one) YES | NO
   If NO, then what is the language spoken at home? _______________________

If your response to <u>any</u> of the questions above was NO:
How many years has the student gone to school in the US? _____________
Assess the student's language proficiency in your opinion. (Check all that apply)

____ Speaks no English	____ Reads no English	____ Writes no English
____ Speaks limited English	____ Reads limited English	____ Writes limited English
____ Speaks English well	____ Reads English well	____ Writes English well

We are required to do an English Language Proficiency Assessment (ELPA) with your child. This is a simple language assessment tool to evaluate English language skills and will determine the language needs of your child. Once the assessment is completed we will notify you of your child's proficiency level. If your child is eligible for English language services, your consent is needed prior to participation in the program.

_______ Check if you give consent Signature: __________________________________

SIGNATURE REQUIRED REGARDLESS OF YOUR ANSWERS

Parent/Guardian's Name (Print): ____

Signature: ____ Date: ___/___/______

Address: ____

Phone Number: ______________________ Cell Number: ______________________

STUDENT INTERNET/COMPUTER ACCEPTABLE USE POLICY

Internet services are available to all students for the purposes of instruction, curriculum support, and communication. E-mail, network, and Internet access is to be used ONLY for these purposes.

Students are expected to conduct themselves ethically and be mindful of all applicable laws and regulations. They should be familiar with procedures for accessing email and/or the Internet and have participated in training provided by the school. Students should have specific information objectives and/or search strategies formulated before they access the Internet. School policy states that ALL students must have a signed Acceptable Use Policy form on file before they are allowed to use the Internet independently.

The following are unacceptable uses of e-mail/Internet by students who access the network through school accounts using school-owned equipment and may result in the revocation of Internet privileges or, depending on the nature of the offense, detention or suspension.

Unacceptable use includes but is not limited to:

- Sending or displaying offensive messages or pictures
- Using obscene, harassing, or insulting language
- Violating copyright laws or fair-use practices
- Trespassing in others' folders, documents, or files
- Using the network for commercial or political purposes
- Using the network to access inappropriate materials
- Intentionally damaging computers, computer systems, or computer networks
- Using another person's password
- Indiscriminate personal use – purchases, personal emailing, or "instant messaging"
- Downloading software without permission of school administration or network technician
- Other behaviors in violation of Academy policy, state statutes, or federal laws

Communication over networks is not considered private. Network supervision and security maintenance may require monitoring of directories, messages, or Internet activity. The Academy reserves the right to access stored records in cases where there is reasonable cause to expect wrong-doing or misuse of the system.

Student Internet/Computer Acceptable Use Policy – SIGNATURE MANDATORY

Student Name: ____ Grade: ___________

I have read the Student Internet Acceptable Use Policy. I agree to follow the rules contained in this policy with an understanding that consequences could entail revocation of internet privileges, or depending on the nature of the offense, detention or suspension. I will receive a copy of this signed Policy and a copy will be kept in my file.

Student Signature: ____ Date: ___/___/______

Parent Signature: ____ Date:___/___/______

PHOTO POLICY-CONSENT/DENIAL

In an effort to keep the community up-to-date on events, the Academy will, on occasion, invite local media representatives into our school to photograph special programs and events. Media representatives register at the main office upon their arrival and are always escorted to the designated area from which they can take photos or video publications. We do not allow media representatives to interview students on school property unless academy personnel accompany them.

Academy personnel will also take pictures of classroom activities and/or individual students from time to time for either release to the local media, use in the Academy web site, or for Academy media or brochures. Identification of students is always limited to name, school, and grade.

Please note: Permission to photograph a student either individually or in a group, and to use any photograph for any school purpose, is assumed until you specifically request your child's photo not be used. This information will be kept on file in the student's records.

I, ___________________________________, am the legal guardian of ________________________________
(Parent/Guardian Full Name) (Student's Full Name)

who will be in ________ grade in 2017-18, and:

☐ I DO NOT want my child's picture to be used in school-related or outside media publications.

OR

☐ I give my permission for my child's picture to be used in school-related or outside media publications.

Home address: ____

Home telephone #: ____________________________ Mobile phone #: ____________________________

Work phone #: _____________________________

Parent Signature: ____ Date: ___/___/______

Student Residency Questionnaire

Student's Name: ____

Academy Name: ____

This questionnaire is given to ALL students to ensure our academy remains in compliance with federal law. Your answers will help academy staff determine if the student is eligible for certain rights under federal law and supportive services.

The student lives in the following situation:

- ☐ Owner-occupied home
- ☐ Rental unit
- ☐ Emergency shelter or transitional housing*
- ☐ Motel/hotel*
- ☐ Campground*
- ☐ Public or private place not designed for or ordinarily used as regular sleeping accommodation for humans, including cars, parks, public spaces, abandoned buildings, substandard housing, or bus or train stations*
- ☐ Foster care placement for 6 months or less*
- ☐ Long-term, stable, cooperative living arrangement
- ☐ Temporary, shared housing with friends, family or others due to:
  - ☐ Loss of personal housing* (due to reasons such as eviction, inability to pay rent, destruction or damage to home, abuse or neglect, unhealthy conditions, parental abandonment or incarceration)
  - ☐ Economic hardship*
  - ☐ Other, similar reason: ___________________________________*

*Living in these situations may qualify you for services, including transportation, school supplies, educational advocacy, and community referrals.

Parent name (printed): ____

Parent Signature:____

Date: ________________________

HEALTH APPRAISAL

Dear Parent or Guardian: The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. (**BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION**.)

PERSONAL

CHILD'S NAME (Last, First, Middle)			DATE OF BIRTH (mm/dd/yy) / /
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER ( )
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	WORK TELEPHONE NUMBER ( )

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?
☐	☐	☐	1 Allergies or Reactions (for example, food, medication or other)
☐	☐	☐	2 Hay Fever, Asthma, or Wheezing
☐	☐	☐	3 Eczema or Frequent Skin Rashes
☐	☐	☐	4 Convulsions/Seizures
☐	☐	☐	5 Heart Trouble
☐	☐	☐	6 Diabetes
☐	☐	☐	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements
☐	☐	☐	9 Shortness of Breath
☐	☐	☐	10 Speech Problems
☐	☐	☐	11 Menstrual Problems
☐	☐	☐	12 Dental Problems: Date of Last Exam / /
☐	☐	☐	Other (please describe):
☐	☐		Does your child take any medication(s) regularly?

Reason for Medication

Birth History:

Are there any current or past diagnosis(es) ☐ Yes ☐ No

If yes, please describe:

If yes, list medications:

⇨

/ /

Parent/Guardian Signature Date

Was the health history reviewed by a health professional?

☐ Yes ☐ No ***Examiner's Initials:***

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	VISION	Visual Acuity			
			Muscle Imbalance			
		Date: / /	Other:			
☐	☐	HEARING	Audiometer			
			Other:			
		Date: / /				
☐	☐	URINALYSIS	Sugar			
			Albumin			
		Date: / /	Microscopic			
☐	☐	BLOOD LEAD LEVEL Date: / /	Level ______ ug/dl ⇨			

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
☐	☐	Other:	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading:			
☐	☐	TUBERCULIN Date: / /	Type: Neg.: ☐ Pos.: ☐ ______ mm			

NOTE: Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.

Examinations and/or Inspections

Essential Findings Deviating from Normal:

Exam Date: / /

SECTION III - IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3
	2	
DTaP/DTP/DT/Td	1	4
	2	5
	3	6
Tdap	1	
Haemophilus Influenzae type b (HIB)	1	3
	2	4
Polio (IPV/OPV)	1	3
	2	4
Pneumococcal Conjugate (PCV7/PCV13)	1	3
	2	4
Rotavirus (RV1/RV5)	1	3
	2	
Measles,Mumps, Rubella (MMR)	1	2
Varicella (Chickenpox)	1	2

History of Chickenpox Disease? ☐ Yes ☐ No If yes, date:

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (HepA)	1	2
Influenza (IIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	2	
OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	1	
	2	
	3	

Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable

*NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your provider office for medical waiver forms and through your local health department for nonmedical waiver forms.

Parent/Guardian refused immunizations: ☐

I certify that the immunization dates are true to the best of my knowledge

Health Professional's Signature ______ Title ______ Date ___ / ___ / ___

SECTION IV - RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

No	Yes	
☐	☐	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain:
☐	☐	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): ☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Other

Other Recommendations

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined ______ (child's name)'s teeth. As a result of this examination, my recommendation for treatment is: ______

Dentist's Signature ______ Date ___ / ___ / ___

PHYSICIAN'S SIGNATURE

Examiner's Signature ______ Date ___ / ___ / ___ *Examiner's Name (Print or Type)* ______ Degree or License ______

Number & Street ______ City ______ MI ZIP Code ______ ( ) Telephone ______

Information required for:

Early On - Hearing and Vision Status; Diagnosis; Health Status

Child Care Licensing - Physical Exam, Restrictions, Immunizations

Head Start/Early Head Start - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-child care visit required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.

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Developed in Cooperation with the Department of Health and Human Services, Education, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.