Student Enrollment Form

Student Name (last, first): _____

Student ID#: Date:

STUDENT INFORMATION (Please Print)

(Enter the student name as it appears on the birth certificate, passport or other official document)

Student's Legal Last Name	First Name	Middle	Suffix (Jr, III)

Date of Birth	Grade at Enrollment	Age

Gender (Male/Female)	Birthplace (City, State, Country)	Nickname

Student's Personal Email	Student's Cell Phone Number

STUDENT PRIMARY PHYSICAL ADDRESS (Enter the Michigan address at which the student lives the majority of the time)

Address Number and Street Name	Apartment / Lot# / Unit

CIty	State	Zip Code

County	Home Phone Number	Phone Unlisted?
		❒ Yes ❒ No

Is the mailing address different than the primary physical address above? ❒ Yes ❒ No

STUDENT MAILING ADDRESS (If different than the primary physical address. NOTE: This will usually be a PO Box. If the student splits time between two households, there will be an opportunity to enter a second parent/guardian address later in the form.)

Address Number and Street Name	Apartment / Lot# / Unit

CIty	State	Zip Code

PREVIOUS SCHOOL ATTENDED (Include Preschool through 12th Grade)

School Name	Address

CIty	State	Zip Code

Country	Phone Number	Fax Number

STUDENT'S ETHNIC GROUP

Part A: Student's Ethnicity

Is the student of Hispanic/Latino descent? ❒ Yes ❒ No
(A person of Cuban, Mexican, Puerto Rican, South or Central America or other Spanish culture or origin, regardless of race.)

Is the student of Arab descent? ❒ Yes ❒ No

Part B: Student's Race: Choose one or more

❒ **American Indian or Alaskan Native** - A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

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

❒ **Native Hawaiian/Pacific Islander** - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

❒ **African American/Black** - A person having origins in any of the black racial groups of Africa.

❒ **White** - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Student Enrollment Form

Student Information

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN 1 (Lives at the same primary physical address as the student)

Parent/Guardian Last Name (1) | Parent/Guardian FIrst Name | Cell Phone

Name of Employer/Occupation | Work Phone

Relationship to Student | Email Address

Is this person a custodial parent? ▫ Yes ▫ No

At which phone number do you want to receive school communications? ▫ Home ▫ Cell ▫ Work ▫ Do not call

Preferred voice message language:

Preferred email language:

Are there any court-ordered restrictions to contact with the student by this parent/guardian? ▫ Yes ▫ No If yes, please specify:

PARENT/GUARDIAN 2

Parent/Guardian Last Name (2) | Parent/Guardian FIrst Name | Cell Phone

Name of Employer/Occupation | Work Phone

Relationship to Student | Email Address

Is this person a custodial parent? ▫ Yes ▫ No

Does student reside with the person? ▫ Yes ▫ No

If not at same address as student, does parent/guardian want to receive copies of mailings? ▫ Yes ▫ No

If yes, enter address here:

Are there any court-ordered restrictions to contact with the student by this parent/guardian? ▫ Yes ▫ No If yes, please specify:

At which phone number do you want to receive school communications? ▫ Home ▫ Cell ▫ Work ▫ Do not call

Preferred voice message language:

Preferred email language:

PARENT/GUARDIAN 3

Parent / Guardian Last Name (3) | Parent / Guardian FIrst Name | Cell Phone

Name of Employer/Occupation | Work Phone

Relationship to Student | Email Address

Is this person a custodial parent? ▫ Yes ▫ No

Does student reside with the person? ▫ Yes ▫ No

If not at same address as student, does parent/guardian want to receive copies of mailings? ▫ Yes ▫ No

If yes, enter address here:

Are there any court-ordered restrictions to contact with the student by this parent/guardian? ▫ Yes ▫ No If yes, please specify:

At which phone number do you want to receive school communications? ▫ Home ▫ Cell ▫ Work ▫ Do not call

Preferred voice message language:

Preferred email language:

Student Enrollment Form

Student Information

PARENT/GUARDIAN 4

Parent / Guardian Last Name (3)	Parent / Guardian FIrst Name	Cell Phone

Name of Employer/Occupation	Work Phone

Relationship to Student	Email Address

Is this person a custodial parent? ▫ Yes ▫ No

Does student reside with the person? ▫ Yes ▫ No

If not at same address as student, does parent/guardian want to receive copies of mailings? ▫ Yes ▫ No

If yes, enter address here:

Are there any court-ordered restrictions to contact with the student by this parent/guardian? ▫ Yes ▫ No If yes, please specify:

At which phone number do you want to receive school communications? ▫ Home ▫ Cell ▫ Work ▫ Do not call

Preferred voice message language:

Preferred email language:

SCHOOL AGE SIBLINGS (If there are more than 3, please continue on the back of the sheet)

Student Last name, First name	Age	School	Date of Birth
Student Last name, First name	Age	School	Date of Birth
Student Last name, First name	Age	School	Date of Birth

OPTION TO RECEIVE TEXT MESSAGES IN THE EVENT OF SCHOOL CLOSURES

The Ann Arbor Public Schools is considering the use of text messaging for alerting families about school closures such as snow days. Please indicate your interest in such an option below.

Parents/guardians providing cell phone numbers would be given an opportunity to opt into text messages starting in the fall. Please note, although the district does not charge you for this service, it does not pay for text message charges that may be incurred by you for sending or receiving text messages. Check with your wireless carrier for possible charges. Message and Data rates may apply.

*** Please Select:**

▫ Our family would be interested in receiving school closure information via text message.

▫ We would **NOT** be interested in receiving school closure information via text message.

This enrollment packet was submitted by:

Parent/Guardian **Date**

My signature below indicates that I have reviewed the original enrollment packet and have verified all information is correct and accurate.

Initials of parent/guardian: _____ **Date:** _____

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ANN ARBOR PUBLIC SCHOOLS

Student Enrollment Form

Student Name (last, first): _____

Student ID#: Date:

HOME LANGUAGE SURVEY

The Ann Arbor Public School District is collecting information regarding the language background of each of its students. This information will be used by the district to determine the number of children who should be provided bilingual instruction according to Sections 380.1152-380.1157 of the School Code of 1995, Michigan's Bilingual Education Law. Thank you for your cooperation.

Is the student's first language (native tongue) something other than English? ❒ Yes ❒ No

Please specify the language: _____

Is the primary language used in your child's home or environment a language other than English? Note: "Primary language" means the dominant language used by a person for communication. ❒ Yes ❒ No

Please specify the language: _____

Is this the first time your child has enrolled in a school in the United States? ❒ Yes ❒ No

Please Explain: _____

When did your child first enroll in a school in the United States?

Date (mm/dd/yyyy): _____

My child first started to speak English at how many years old:

Please Explain: _____

EDUCATIONAL NEEDS/ SERVICES INFORMATION

Has the student received any IEPC/IFSP/IEP/MET Special Education Services or a 504 Plan? ❒ Yes ❒ No

Please Explain: _____

❒ Yes ❒ No

Has student received any IEPC/IEP Special Education Services?

What Years? _____

School district: _____

Services: _____

Has student had a 504 plan? ❒ Yes ❒ No

School district: _____

Services: _____

Parent/ Guardian Signature Date

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ANN ARBOR PUBLIC SCHOOLS

Student Enrollment Form

Student Name (last, first): _____

Student ID#: Date:

HEALTH INFORMATION

If your child does have a medical concern, the nurse will contact you to obtain more information as needed, to plan for the upcoming school year. This form is not a medication authorization form. If your student will or may require medication at school, contact the school's office. Please note: a medication administration form is required for **ALL** medication taken at school, even over the counter medications. This information will be shared with appropriate school staff.

HEALTH CONCERNS

❒ Asthma*
❒ Cardiac condition
❒ Corrective lenses
❒ Diabetes
❒ Dietary restrictions
❒ Migraines
❒ Mild Food, Insect, or Seasonal Allergies
❒ Seizure Disorder
❒ Severe allergies/Anaphylaxis
❒ Other health condition
*If you select Asthma, please complete the Asthma Survey on the next Page.

Please provide more information for selected concerns:

MEDICATIONS

Does your student require any medications to be given while they are at school (including over-the-counter medications)?	❒ Yes ❒ No
Does your student require any medications that the student needs to be permitted to carry and self-administer (including over-the-counter medications)?	❒ Yes ❒ No

RELIGIOUS OBJECTIONS

Any religious objections, restrictions or requirements that should be relayed to building staff and/or emergency personnel?	❒ Yes ❒ No
Please specify:	

IMMUNIZATIONS

Student Has Had Chickenpox:	❒ Yes ❒ No
Approximate Date (MM/DD/YYYY)	
Date of the most recent DtaP:	

Student Enrollment Form

Student Information

PREFERRED HOSPITAL

▯ None at this time

Hospital Name | Phone

When was your child's last asthma episode?

Address Number and Street Name

City | State | Zipcode

DENTIST

▯ None at this time

Dentist Name | Phone

Address Number and Street Name

City | State | Zipcode

ASTHMA SURVEY

Did a doctor diagnose your child's asthma?	▯ Yes ▯ No
Approximate Date of Diagnosis	
When was the last time your child saw a health care provider for asthma?	
Does your child take daily asthma medication (maintenance medication)?	▯ Yes ▯ No
Does your child have a rescue inhaler (example - albuterol)?	▯ Yes ▯ No
When was your child's last asthma episode?	
Do you plan to have a rescue inhaler for your child at school this year?	▯ Yes ▯ No
Date of last prescription for Asthma medication:	
Does the student have an Asthma Action Plan?	▯ Yes ▯ No
What triggers your child's asthma?	

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Student Enrollment Form

Student Name (last, first): _____

Student ID#: Date:

CONSENT FOR DISCLOSURE OF IMMUNIZATION INFORMATION TO LOCAL AND STATE HEALTH DEPARTMENTS

Immunizations are an important part of keeping our children healthy. Schools and State and Local health departments must monitor immunization levels to ensure that all communities are protected from potentially life-threatening diseases and, if necessary, respond promptly to an emerging public health threat. It is important that disease threats be minimized through the monitoring of students being immunized.

Sharing immunization and personally identifiable information including the students name, Date of Birth, gender, and address with local and state health departments will help to keep your child safe from vaccine preventable diseases. The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g, requires written parental consent before personally identifiable information from your child's education records is disclosed to the health department. If your child is 18 or over, he or she is an "eligible student" and must provide consent for disclosures of information from his or her education records.

You may withdraw your consent to share this information in writing at any time.

❒ I DO authorize the Ann Arbor Public Schools to release my child's immunization record to the Michigan Department of Health and Human Services and Local Health Department. I understand this information will be used to improve the quality and timeliness of immunization services and to help schools comply with Michigan Law. This includes any immunization information and limited personally identifiable information from the school.

❒ I DO NOT authorize the Ann Arbor Public Schools to release my child's immunization record to the Michigan Department of Health and Human Services and Local Health Department.

Parent/ Guardian Signature Date

PARENT/GUARDIAN CERTIFICATION

I certify that the information provided herein is current and true, and by my signature below acknowledge Ann Arbor Public Schools' lawful right to disenroll my child and to charge prorated tuition to the family of any student who has been found to have misrepresented residency in the Ann Arbor Public School District.

Parent/ Guardian Signature Date

Parent/ Guardian Printed Name

ANN ARBOR PUBLIC SCHOOLS STATEMENT OF NON-DISCRIMINATION

No person shall be excluded from participation in, be denied the benefits of, or be subjected to discrimination in any educational program or activity available in any school on the basis of race, color, sex, religion, creed, political belief, age, national origin, linguistic and language differences, sexual orientation, gender, gender identity, gender expression, socioeconomic status, height, weight, marital or familial status, disability or veteran status. The following person has been designated to handle inquiries regarding the nondiscrimination policies: The Executive Director of Human Resources, 2555 S. State Street, Ann Arbor, MI 48104 (734) 994-9444.

Ann Arbor Public Schools W. Scott Westerman
Preschool and Family Center
2775 Boardwalk
Ann Arbor, MI 48104
(734) 997-1245
Fax: (734) 994-2895

Dear Parent/Guardian,

In order to enroll your child in a program or to receive services here at the Westerman Preschool and Family Center we need to process an enrollment for your child.

Please print off the enrollment packet and complete all pages.

Alternately, you can print, complete, scan, and email the enrollment documents back to me.

Bring the completed enrollment forms along with the following documentation to the Preschool & Family Center.

Your Driver's License
Original Birth Certificate (copies cannot be accepted and must be translated to English)
Proof of Residency (e.g. *current* lease, if rent or mortgage/tax bill, if own house or DTE bill)
Proof of Immunization & most recent Physical from child's pediatrician
(either the form in the packet or the pediatrician's own form, keeping in mind that physicals are good for 1 year from the date of exam, not from the date the paper is filled out)

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ANN ARBOR PUBLIC SCHOOLS

Ann Arbor Public Schools Early Childhood Program — Emergency Card

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

For Provider Use Only:	Date of Admission	Date of Discharge	Student ID (If relevant)	Teacher

Name of Child (Last, First, Middle Initial)		Home Phone	Child's Date of Birth
Address (Number and Street, Building/Apartment Number)		City	State / Zip Code

Primary Parent/Legal Guardian's Name	☐ Lives with Child ☐ Has custody of Child	**Secondary Parent/Legal Guardian's Name**	☐ Lives with Child ☐ Has custody of Child
Home Phone	Cell Phone	Home Phone	Cell Phone
Home Address (if not child's address)		Home Address (if not child's address)	
City / State / Zip Code		City / State / Zip Code	
Email Address (optional)		Email Address (optional)	
Employer Name	Work Phone	Employer Name	Work Phone
Name of Child's Physician/Health Clinic	Phone	Name of Child's Dentist/Dental Clinic	Phone

Allergies, Special Needs and Special Instructions (Attach additional sheets, If necessary):

Emergency Contact & Release of Child: List all individuals, in order of preference, to be contacted in an emergency. Parents/legal guardians will automatically be contacted first, if possible include at least one other person to be contacted in an emergency and to whom the child can be released. If you wish to list a person for Release of Child only, do not include a phone number. (If more individuals, attach additional sheets.)				**REL of Child (X)**
1.	Relation to child	( )	☐ Cell ☐ Home	
2.	Relation to child	( )	☐ Cell ☐ Home	
3.	Relation to child	( )	☐ Cell ☐ Home	
4.	Relation to child	( )	☐ Cell ☐ Home	
5.	Relation to child	( )	☐ Cell ☐ Home	

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Emergency Contact & Release of Child: Continued				REL of Child (X)
6.	Relation to child	( )	☐ Cell ☐ Home	
7.	Relation to child	( )	☐ Cell ☐ Home	
8.	Relation to child	( )	☐ Cell ☐ Home	

Screening Tests: I hereby give consent to the Ann Arbor Public Schools Early Childhood Program to perform Hemoglobin, Vision & Hearing Screenings, Developmental & Behavioral Screenings, and Mental Health Consultation Services.

Signature of Parent/Guardian **Date**

_____ _____

Field Trips: I hereby give consent to the Ann Arbor Public Schools Early Childhood Program for my child to be transported in a vehicle and/or participate in field trips. ☐ **Yes** ☐ **No**

Emergency Treatment: I hereby give consent to the Ann Arbor Public Schools Early Childhood Program, licensed by the Department of Human Services, to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care. ☐ **Yes** ☐ **No**

AUTHORITY: Act 116 of P.A. 1973 COMPLETION: Required PENALTY: Rule Violation Citation

Release of Information: I hereby give consent to the Ann Arbor Public Schools Early Childhood Program, my child's physician/dentist and/or health clinic to release and/or exchange oral and/or written information regarding my child. ☐ **Yes** ☐ **No**

I certify that I accurately completed this form and if anything changes, I will notify Ann Arbor Public Schools by updating this form.

Signature of Parent/Guardian **Date**

_____ _____

The information listed above is correct.

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials

Ann Arbor Public Schools and its affiliates will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender, identity or expression, political beliefs or disability.

Ann Arbor Public Schools W. Scott Westerman
Preschool and Family Center
2775 Boardwalk
Ann Arbor, MI 48104
(734) 997-1245
Fax: (734) 994-2895

PERMISSION TO PUBLISH

Students who attend the Ann Arbor Public Schools ("District") may occasionally be asked to participate in school and/or District publicity, publications, and/or public relations activities ("Publication Activities"). Publication Activities may include videotaping, recording and/or photographs that may be published, displayed, distributed, or broadcast outside by the District or third parties with District consent. Publication Activities may include use of the student's name, photograph, art, written work, voice, verbal statements or portrait (video or still) in school publicity, District publications, videos, digital or electronic media or on the District website. For example, pictures and articles about school activities may appear in local newspapers or District publications.

The District does not anticipate commercial use or sale of your student's name, picture, art, written work, voice, verbal statements, portraits (video or still). However, to the extent works described in this form result in any profits, by signing this form you and your student agree to waive any and all rights to any copyright interest in such works and any royalties that may be paid. Any profits generated by the works described in this form will be used to benefit the Ann Arbor Public Schools and its programs.

☐ I **PERMIT** use of this student's image and work to be used in school and/or District publicity, publications, and/or public relations activities.

☐ I **DO NOT** permit use of this student's image and work to be used in school and/or District publicity, publications, and/or public relations activities.

Child's name: _____

Parent Signature: _____ Date: _____

Ann Arbor Public Schools W. Scott Westerman
Preschool and Family Center
2775 Boardwalk
Ann Arbor, MI 48104
(734) 997-1245
Fax: (734) 994-2895

Dear Families,

There are many students in our school that have a serious nut allergy – the food allergy that claims more lives each year than any other. A child with a serious nut allergy can suffer a reaction merely by touching a nut containing food. Therefore, we are putting the following safety guidelines into effect:

- Please do not send any nuts, peanut butter or foods containing nuts or peanut butter to be eaten in the classroom.
- We will not be doing any classroom projects that involve peanut butter (like bird feeders) or peanut shells (art projects) or any materials that might contain nuts or nut products.
- If your child ate peanut butter for breakfast, we would greatly appreciate your making sure that his/her hands are washed with soap and water before leaving for school. Water alone does not do the trick!

This is a learning process for all of us, but we trust that you understand how deeply important it is to respect and adhere to these guidelines. If throughout the course of the year you have any questions or concerns about food allergy-related issues, please do not hesitate to contact any one of us.

We appreciate your support of these procedures. We believe all families understand a parent's concern and worry about safety and will join us in ensuring that our environment is conducive to this goal. Please complete and return this form so that we are sure that every family has received this information. If you have any questions regarding ingredient lists or other questions, please contact any one of us.

I have read and understand the procedures to not allow **NUTS IN THE CLASSROOM**. I agree to do my part in keeping nuts and nut products out of the classroom.

Child's name: _____

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:

_____ / / Was the health history reviewed by a health professional?

Parent/Guardian Signature Date ☐ 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 Date: / /	Visual Acuity			
			Muscle Imbalance			
			Other:			
☐	☐	HEARING Date: / /	Audiometer			
			Other:			
☐	☐	URINALYSIS Date: / /	Sugar			
			Albumin			
			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	
	Type of Vaccine(s)	Date of Vaccine(s)
OTHER Vaccines Specify Date & Type	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 _____ 's teeth. As a result of this examination, my recommendation for treatment is: _____

child's name

_____ ___/___/___

Dentist's Signature Date

PHYSICIAN'S SIGNATURE

_____ ___/___/___ _____ _____

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

_____ _____ MI _____ (___) _____

Number & Street City 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.

****

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.

Ann Arbor Public Schools W. Scott Westerman
Preschool and Family Center
2775 Boardwalk
Ann Arbor, MI 48104
(734) 997-1245
Fax: (734) 994-2895

Transportation Request

Please select:
□ **CHANGE in transportation**
□ **NEW transportation request**
□ **Lift Bus Needed**

TODAY'S DATE: _____ DATE TO BEGIN: _____

Student Name: _____

Home Address: _____

Pick Up Location: _____
If this is a childcare facility or daycare, include the name, address and phone number of facility or provider
Drop Off Location:_____
If this is a childcare facility or daycare, include the name, address and phone number of facility or provider

Door to Door pick up requested (Special Equipment ONLY)_____ *
All adults must be listed on the emergency form and have a photo I.D. in order to "pick up" the child
Bus Safety Notice:
For the safety of your child, it is required that all children are escorted to and from the bus at all times.
Adults "picking up" the child from the bus need to:
□ *Be at the bus*
□ *Must be 12 or older and listed as authorized person on the child emergency card*
□ *Must have photo identification*
□ *Child must have bus tag for identification on backpack*
□ *Bus drivers will not wait or honk for families who are not standing at the bus stop at the designated times*

By signing below, I agree to adhere to the bus safety policy.
I also understand that I will only be allowed to request 3 changes to my transportation throughout the school year. Changes can only be made once a month and can take up to a month to begin. I also understand that if my child is returned to the preschool (i.e. no one is at the stop to pick up the child), I may lose my transportation privileges.

TEACHER:_____ SESSION: AM PM FULL DAY

Parent Signature:_____ Date: _____

Rev. 5/31/18