A Renaissance School Services Partnership School

Taylor International Academy

2016-2017 Enrollment Check List

Please submit all portions of the Enrollment Packet together. In order to finalize enrollment at Taylor International Academy, all enrollment requirements and documents must be completed.

Student Name: ______________________________ **Grade:** ____________

Please complete and return the following forms:

- ☐ Enrollment Form — Staff Initials ________ Date Rec'd ________
- ☐ Media Release — Staff Initials ________ Date Rec'd ________
- ☐ Health Appraisal Form (New, K, 7th grade) — Staff Initials ________ Date Rec'd ________
- ☐ Records Request Form (not for Pre-K or K) — Staff Initials ________ Date Rec'd ________

Please provide a copy of the following documents:

- ☐ Guardian's ID (Driver's License or State ID) — Staff Initials ________ Date Rec'd ________
- ☐ Student's Birth Certificate — Staff Initials ________ Date Rec'd ________
- ☐ Student's Immunization Records — Staff Initials ________ Date Rec'd ________
- ☐ Student's Final Report Card — Staff Initials ________ Date Rec'd ________
- ☐ IEP Record if applicable — Staff Initials ________ Date Rec'd ________

GSRP Applications, please provide the following documents:

- ☐ Proof of Income — Staff Initials________Date Rec'd_
- ☐ Head Start Waiver — Staff Initials________Date Rec'd_
- ☐ Notice of Licensing — Staff Initials________Date Rec'd_
- ☐ Risk Factor documentation — Staff Initials________Date Rec'd_

☐ *Entered in Recruitment Tracker: Initials________ Date________*

☐ *Entered in MISTAR: Initials________ Date________*

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2016-17 Enrollment Form

School Office Use Only

Date Application Received		Student UIC#		Start Date	

Application Information			
Date		Grade Applying for *(Please check one)*	Pre-K ☐ K ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 7th ☐ 8th

Student Information					
Last Name		First Name		Middle Name	
Date of Birth		Gender	☐ Male ☐ Female	Last Grade Completed	
Ethnicity *(Please check one)*	☐ African American ☐ Asian ☐ American Indian ☐ Hispanic ☐ Caucasian ☐ Latino ☐ Other:				
Previous School Attended		District			
Is your student currently under suspension/expulsion from another academy or school district? *(Please check one)*	☐ Yes ☐ No				
Does your student have an IEP, 504 plan, and/or require school-based special services? *(Please check one)*	☐ Yes ☐ No *If yes, please provide a copy of the IEP/504 Plan.*				

Contact Information							
Home Address							
City		State		Zip		Home Phone	

Parent/Guardian Information					
Last Name		First Name		Relationship to student	
Home Phone		Cell Phone		Email Address	
Last Name		First Name		Relationship to student	
Home Phone		Cell Phone		Email Address	
Student Resides with *(Please check one)*	☐ Both Parents ☐ Mother ☐ Father ☐ Guardian ☐ Other:_____________				

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Student Sibling(s) *(Only if currently attending or enrolling at the Academy)*				
1. *Last Name, First Name*	Grade Entering		Date of Birth	
2. *Last Name, First Name*	Grade Entering		Date of Birth	
3. *Last Name, First Name*	Grade Entering		Date of Birth	
4. *Last Name, First Name*	Grade Entering		Date of Birth	

Emergency Contact Information *Should the student become ill during the school day and/or we cannot contact parents / guardians please list emergency contacts in order of preference. Identification will be required to release the student.*				
1. *Last Name, First Name*	Phone 1		Relationship to Student	
	Phone 2			
2. *Last Name, First Name*	Phone 1		Relationship to Student	
	Phone 2			
3. *Last Name, First Name*	Phone 1		Relationship to Student	
	Phone 2			

Medical Information- *Physician / Insurance information is optional and will only be used in cases of emergency.*					
Physician First Name		Last Name		Phone	
List medical conditions (allergies, health conditions etc.) or other information which you want teachers and office personnel to know.					
By listing this information here, I agree to share this information with school officials. Parent/Guardian Initials ____________					
☐ I give permission to Taylor International Academy to take immediate action necessary for the preservation of the student's health in the event of medical emergency.					
☐ I DO NOT give Taylor International Academy to take immediate action necessary for the preservation of the student's health in the event of medical emergency.					

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McKinney-Vento Act Questionnaire *The answers to the following questions can help determine the services this student may be eligible to receive the McKinney-Vento Act 42 U.S.C. 11435.*
1. Is this student's home address a temporary living arrangement? ☐ Yes ☐ No 2. Is this a temporary living arrangement due to loss of housing or economic hardship? ☐ Yes ☐ No 3. Is this student in temporary or emergency foster care placement? ☐ Yes ☐ No 4. As a student, are you living with someone other than your parent or legal guardian? ☐ Yes ☐ No
How did you hear about Taylor International Academy? ☐Newspaper ☐Radio ☐Church ☐Family/Friend: ________________ ☐Referred By: __________________ ☐Other: ______________

Consent & Signature

By signing, I am confirming that the information given is true to the best of my knowledge and that I have read, understand and agree to the terms which are listed on this application. Failure to report accurate information could result in your child being withdrawn from the Academy. I agree to support the Parent/Student Handbook and the philosophy and polices of Taylor International Academy.

***Signature of Parent/Guardian: ___________________________________ Date: ________________**

Completed enrollment applications may be submitted in person, by mail, or fax.

Mail to: Taylor International Academy Attn: Registrar; 26555 Franklin Road, Southfield, MI 48033

Fax: 248-354-1501

Taylor International Academy admits students of any race, color, religion, national and ethnic origin to all the rights, privileges, programs, and activities generally accorded or made available to students at the school. It does not discriminate on the basis of race; color, religion, national and ethnic origin in administration of its educational policies, admissions policies, athletic and other school administered programs.

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Media Release

Dear Parent/Guardian:

During the school year, your child's image/photograph or work may be used in one of the following ways:

- Used as a part of a demonstration, image, or video in educational workshops, classes, or conferences.
- Used in projects or videos created by the school staff or students for use inside the school.
- Posted on the school's website on the internet or the school's Facebook page.
- Used on school-created marketing material to advertise the school.
- Submitted as part of grant applications or contest entries to sponsors.
- Videotaped to appear in a school-related program or news broadcast to be used by a local television station or school/county project.
- Used in a printed publication such as a newspaper, magazine, or yearbook.

Your child's name or address WILL NOT be included with your child's picture when publishing on the internet. There is no monetary compensation for the use of any media containing your child's image or work. Please sign the release form below and return to the school. Your permission grants us approval to publicize without prior notification and will remain in effect until revoked.

<u>Release Authorization</u>

☐ I **DO** give permission for my child's image, photograph, or school work to be used as described above. We are willing to release this into the public domain and understand that no monetary compensation will be given for the use of the materials.

☐ I **DO NOT** give permission my child's image, photograph, or school work to be used as described above.

Student Name: ____ Grade: _______________

____

Parent/Guardian Signature Date

This form will stay in effect for the duration of enrollment at Taylor International Academy. If at any time you wish to change this form, please contact the main office.

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Authorization to Release Student Records

The following student has enrolled at Taylor International Academy and requests that your district sends all student records including academic, disciplinary, IEP, and/or State assessment records to Taylor International Academy at the address/fax number listed below.

Taylor International Academy
Attn: Student Registration
26555 Franklin Road
Southfield, MI 48033

Fax: (248) 354-1501

Student Name: ____

Current Grade: ___________ **Date of Birth:** ___________

Previous School Attended: ____

Address: ____

City: ______________________ **State:** ___________ **Zip:** ________________

Phone: ______________________ **Fax:** ______________________

By signing below, I authorize the release of my child's records to Taylor International Academy.

____
Parent/Guardian Signature **Date**

Office Use Only

Request Mailed/faxed:		**2nd Attempt**		**3rd Attempt**		**4th Attempt**	

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?	Birth History:
☐	☐	☐	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)	Are there any current or past diagnosis(es) ☐ Yes ☐ No
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements	If yes, please describe:
☐	☐	☐	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?	If yes, list medications:
			Reason for Medication	⇨
			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	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	VISION	Visual Acuity				☐	☐	HEIGHT & WEIGHT	Height			
			Muscle Imbalance							Weight			
		Date: / /	Other:				☐	☐	Other:	Other			
☐	☐	HEARING	Audiometer				☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
			Other:				☐	☐	BLOOD PRESSURE	Reading:			
		Date: / /											
☐	☐	URINALYSIS	Sugar				☐	☐	TUBERCULIN	Type:			
			Albumin										
		Date: / /	Microscopic						Date: / /	Neg.: ☐ Pos.: ☐ mm			
☐	☐	BLOOD LEAD LEVEL Date: / /	Level ug/dl ⇨										

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.