

Summit Academy 3 Yr. Old Preschool/2018-19

30100 Olmstead Rd., PO Box 310 Flat Rock MI 48134

Telephone 734 379-6810/Fax 734-379-6745

Welcome to Summit Academy Preschool!

Please review the following list to make sure that you have all of the documentation required for enrollment.

Originals are preferred, however, certified true copies with a seal will be accepted.

Required Items:

- Students must be 3 years of age by September 1st of current school year
- Fully Potty Trained
- Birth Certificate
- Immunization Record
- Health Appraisal
- Copy of parent/guardian driver's license to prove Michigan residency
- Deposit for 1st week of school
- Tuition rates are a weekly flat fee. The same weekly rate is charged if the student attends 1 day or 5 days in the week
- A late pick up fee will be billed for students that are picked up late

Additional documentation that may be required:

- Guardianship/Court Documents
- Custody Court Orders
- Foster Care Court Documents
- Name Change Court Orders

A.M. Class: 8a-11a P.M. Class: 1145a-245p

Work Phone

Cell Phone

Summit Academy 3 Year Old Preschool

*\$45 flat rate per week/Class *\$135 flat rate per week/Full Day

FULL DAY:		Enrollment Applicatior 2018-2019 School Year		week/Full
Received: BC	Imm. HA CO	DL Deposit STUDENT INFORMATION MUST BE AS THEY APPEA	NR ON THE BIRT	TH CERTIFICATE
First Name	Middle Name ***PRESC	Last Name CHOOL STUDENTS MUST B	BE 3 BY SEPTEM	Suffix BER 1 ST OF THIS YEAR.
Address	City	State	Zip	Phone
	Gender Place of Bir	th	Schoo	l District of Residence
	A SA	DISCIPLINE		ng
•	om another school to avoi	id discipline charges or	consequence	s?YESNO
·	violation?	id discipline charges or		
If so, what was the v	violation?	·	INFORMATIO	
If so, what was the v	violation? PRIMARY CONT	FACT PARENT/GUARDIAN	INFORMATIO	
If so, what was the vertical sections of the v	PRIMARY CONT First Name	FACT PARENT/GUARDIAN Last Nam	INFORMATIOI ne	V
Relationship Address Work Phone	PRIMARY CONT First Name City	Last Nam State Email Address	information ne Zip	Home Phone
Relationship Address Work Phone	PRIMARY CONT First Name City Cell Phone CODY ISSUES THE SCHOOL	Last Nam State Email Address	INFORMATION TE Zip	Home Phone
Relationship Address Work Phone **ARE THERE CUST	PRIMARY CONT First Name City Cell Phone SECONDARY CONT	Last Nam State Email Address SHOULD KNOW ABOU ACT PARENT/GUARD	INFORMATION TO THE TO T	Home Phone
Relationship Address Work Phone	PRIMARY CONT First Name City Cell Phone CODY ISSUES THE SCHOOL	Last Nam State Email Address	INFORMATION TO THE TO T	Home Phone

Email Address (used for school notification system)

		ENCY CONTACT INFOR delition to Parents/Guard		I	
My child may be releas	ed to the following people:				
Relationship	Name	Ho	ome	/ Cell	Work
Relationship	Name	H	ome	Cell	Work
Relationship	Name	H	ome	Cell	Work
	STUE	DENT HEALTH INFORMA	ATION		
Is your child subject Yes No If yes, pl	to condition which may ca ease explain:	iuse emergencies suc	h as ep	ilepsy, diabete	es, fainting, allergies, etc.?
action? Yes No If yes, pl Does your child have	e any visual or hearing prolease explain: e any health conditions whees? Yes No If yes, ple	nich may limit particip		·	
Does your child have attention? Yes No If yes, pl	e any other health conditic	ons or medications wh	nich sho	ould be brough	nt to the schools
Has your child had c	hicken pox? Yes No				
		PHOTO RELEASE			
Please chec	idemy North <u>DOES NOT</u> h k only if you <u>DO NOT</u> want or on the website.				

		SIBLING INFORMATION	
Relationship	Name	School Site	Grade
Relationship	Name	School Site	Grade
Relationship	Name	School Site	Grade
		SIGNATURE	
week. ● You DO NOT pa	e a weekly flat fee. The s	same weekly rate is charged if the stunk or Spring Break.	udent attends 1 day or 5 days in the
Parent/Guardian Signat	cure		
Office Use Only			
Signed Contract			
Health Appraisal			
Birth Certificate			
Immunizations			
Drivers License			
Copy of Legal Docs, if custody	issues		
Taken By			•
Date Received			
Consultant Needed			

Summit Academy Flat Rock Elementary 2018-19 School Year

Student Information Form Please fill this out completely

Child's Classroom Color	Q.	Graae	managaman dahan yang garapan g
Student Name		D.O.B	
Address			
City	State	Z ip	AND THE PROPERTY OF THE PROPER
Home Number			
Mother, guardian, step	mother, or m	other figure <i>(Ci</i>	ircle one)
Name	<u> </u>	-	
Address (If different from child City	<u>State</u>	Zip	
Home Phone			
Work phone			
Cell phone			·
Father, guardian, step			one)
Name			
Address (if different from child	ː/s)		
LILY	Dlate		
Home Phone		3	
Work Phone			
Cell phone			
Student lives with			
Medications your child	takes daily		
Medical conditions we			asthma)
Allergies		ده کافیانشده میشود به افظار به است. در پیشتیم به به یکی پیشود و در خواه با دارد و بازی بیشتر بیشت	1, or on the second sec
I have a custody	concern.		
On the surrounding state of the			
ii			
			(OVER)

Emergency Contact Information (Other than parents)

The following people have permission to pick up my child.

Name
Relationship
Home phone
Cell phone
Work phone
Name
Relationship
Home phone
Cell phone
Work phone
Name
Relationship
Home phone
Cell phone
Work phone
My child attends the B.A.S.E/Café program
Signature
Date
Any other information
. day

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 II. 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.)

Was child tested for: Test results: Set all set and set all set and set all se			SONAL												
All	CH	L	O'S NAME (Last, First, Middle)									DATE OF BIRTH (mm	/dd/y ₎	y)	
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City Color City			ATTOUR PRIVATE AND A COLOR	-1.M-A	٠.					NAH		· /			
Cap Code	PAI	1E	N I/GUARDIAN (Last, First, Mi	aale) .								HOME TELEPHONE	NUME	BER	
SECTION I - HEALTH HISTORY												()			
SECTION I - HEALTH HISTORY	ADI	ΟF	ESS (Number & Street)	(City)				(ZIP Co	de)	WORK TELEPHONE	NUME	3ER			
SECTION I - HEALTH HISTORY			•							· MI		()			
# Is your child having any of the problems listed below?				SECT	lOi	V 1 -	- [4]	EΑΙ	LTH	HISTORY					
□ □ 1 Alfarqios or Reactions (for example, food, modication or other) □ □ 2 Hay Fever, Asthma, or Wheating □ □ 3 Convulsions/Salcures □ □ 4 Convulsions/Salcures □ □ 5 Heart Trouble □ □ 7 Frequent Colds, Sore Throsts, Earnches (4 or more per year) □ □ 8 Shortness of Breath □ □ 10 Speech Problems □ □ 10 Speech Problems □ □ 11 Alfarqios of Breath □ □ 10 Speech Problems □ □ 11 Alfarqios of Breath □ □ 10 Speech Problems □ □ 11 Alfarqios of Breath □ □ 10 Speech Problems □ □ 11 Alfarqios of Breath □ □ 10 Speech Problems □ □ 11 Alfarqios of Breath □ □ 10 Speech Problems □ □ 10 Speech Problems □ □ 10 Speech Problems □ □ 11 Alfarqios of Breath □ □ 10 Speech Problems □ 10			olved												
□ □ 2. Hay Perex Asthma, or Wheezing □ □ 3. Eczema or Frequent Skin Rashos □ □ 5. Heart Trouble □ □ 5. Heart Trouble □ □ 7. Frequent Colds, Sore Throats, Earaches (4 or more per year) □ □ 8. Trouble with Passing Urine or Bowel Movements □ □ 10. Speech Problems □ □ 10. Speech Problems □ □ 11. Menstrual Problems □ □ 12. Dental Problems □ □ 13. Exeminations Potential □ □ 10. Speech Problems □ □ 14. Menstrual Problems □ □ 15. Though with Passing Urine or Bowel Movements □ □ 15. Though with Passing Urine or Bowel Movements □ □ 16. Trouble with Passing Urine or Bowel Movements □ □ 17. Frequent Colds, Sore Throats, Earaches (4 or more per year) □ □ 18. Trouble with Passing Urine or Bowel Movements □ □ 19. Speech Problems □ □ 10. Speech Problems □ □ 11. Menstrual Problems □ □ 11. Menstrual Problems □ □ 12. Dental Problems: Date of Lest Exam / / / □ Parent/Costruits (place of the Standard Problems) □ □ 14. Dental Problems: Date of Lest Exam / / / □ Parent/Costruits (place of the Standard Problems) SECTION (I - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS Required for Child Care and Head Standard Fastly Head Standard Fast		Sa								Birth History:					
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□ □ S Heart Trouble □ □ □ 6 Diabetes □ □ □ 7 Frequent Coldis, Sore Throats, Earaches (4 or more per year) □ □ □ 8 Thouble with Passing Urine or Bowel Movements □ □ □ 10 Speach Problems □ □ 11 Menstrual Problems □ □ 12 Dental Problems □ □ 12 Dental Problems Date of Last Exam / / □ □ 12 Dental Problems □ □ 12 Dental Problems □ □ 14 Menstrual Problems □ □ 15 North (Please describe): □ □ 15 Desey your child take any medication(s) regularly? Reason for Medication □ 15 Desey your child take any medication(s) regularly? Reason for Medication □ 16 Sepach Problems: Date of Last Exam / / □ □ 17 Desey your child take any medication(s) regularly? Reason for Medication □ 18 Teach Problems: Date of Last Exam / / □ 19 Desey your child take any medication(s) regularly? Reason for Medication □ 20 Desey your child take any medication(s) regularly? Reason for Medication □ 3 Desey your child take any medication(s) regularly? Reason for Medications: □ 20 Desey your child take any medication(s) regularly? Reason for Medications: □ 3 Desey your child take any medication(s) regularly? Was the health history reviewed by a health professional? □ 18 SECTION N - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS Required for Child Gare and Head Start / Early Hea	[□ □ 3 Eczema or Fr	equent Skin Rashes	-										
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Are there any current or past diagnosis(cs)									\dashv						
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O Other (please describe):	_[_						
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Does your child take any medication(s) regularly? If yes, list medications: If y	Ĺ	1	□ □ 11 Menstrual Pro	blems											
Does your child take any medication(s) regularly? If yes, list medications:	Ε]	□ □ 12 Dental Proble	ms: Date of Last Exam /		/	′	-							
Does your child take any medication(s) regularly? If yes, list medications:]	☐ ☐ Other (please des	scribe):			_								
Reason for Medication / / / Was the health history reviewed by a health professional? Parent/Gwardian Signature Date U'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 Section II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS Required for Child Care and Head Start / Early			"						-						
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### Was the health history reviewed by a health professional? ### Parent/Guardian Signature Parent/Guardian Signature	_			are any medication(s) regularly?							5.				
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VISION	:	SS	Was child tested for:	Test results:	ļ	Ref	l B	2	les Ses	Was child tested for:	Test results:		Nor	Rafe	1
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HEARING Other: Other: URINALYSIS Sugar Albumin Date: / / Meg. Pos. mm NOTE: Blood lead level required for all children enrolled in Medicaid must be test at one and two years of age, or once between three and six years of age if n previously tested. All children under age six living in high-risk areas should be test at the same intervals as listed above. Examinations and/or Inspections Exam Date: / / Exam Date: / /	-	-	Date: / /	Other:	╁		1	_	$ _{\Box} $	Other				+	t
Other: Digite:		1			1	+-	 	ļ			3414	_	+	+	+
Date: _ / _ /			From St. MITTER		-	\vdash	-	닏	닏	DEMOGLOSIY/ REMATOCKII		L-7			
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Statements such as "U	JP-TO-DATE" or		I - IMMUNIZATIONS cepted, Admission to school may be denied	on the basis of this info	rmation.*				
VACCINES (Circle Type)		TE ADMINISTERED MW/DD/YYYY	VACCINES (Circle Type)	DATE ADN	IINISTERED DYYYY				
Hepatitis B	11 3		Hepatitis A (Hep A)	1	2				
(Hep B)	2		T. 7. 7.10 A.0.0	1	3				
	1	4	Influenza (TIV/LAIV)	2	4.				
DTaP/DTP/DT/Td	TaP/DTP/DT/Td 2 5		Meningococcal (MCV4 / MPSV4)	1	2				
	3	6	Human Papillomavirus	1 .	3 .				
Tďap	1		(HPV4/HPV2)	2					
. Haemophilus Influenzae	1	3		Type of Vaccine(s)	Date of Vaccine(s)				
type b (HIB)	2	4	OTHER Vaccines	1					
Polio	1	3.	Specify Date & Type	.2					
(IPV/OPV)	2	4		3					
Pneumococcal Conjugate	1	3	Indicate and attach physician diagnosis	or låboratory evidence of	immunity as applicable				
(PCV7/PCV13)	2	4	*NOTE: According to Public Act 368 of 1	978, any child enrolling is	a Michigan school for				
Rotavirus (RV1/RV5)	1	3	the first time must be adequately	y immunized, vision teste	d and hearing tested.				
·	2		Exemptions to these requirement objections, provided that the wa						
Measles, Mumps, Rubella (MMR)	1 .	2	delivered to school administrator	rs. Forms for these exem					
Varicella (Chickenpox)	1	2	your child's school or local healt	in department.					
History of Chickenpox Disease? ☐ Yes	☐ No If yes, d	late:	Parent/Guardian refused immunizations:						
* Health	Professional's S		Title		Date				
Sey,			RECOMMENDATIONS and Head Start/Early Head Start)						
Is there any defect of vision, hear	ing or other condi	tion for which the school could he	elp by seating or other actions? If yes, please explain	า:					
Should the child's activity be rest If yes, check and explain degree			☐ Gymnasium ☐ Swimming Pool ☐ Competi	itive Sports 🛛 Other					
Other Recommendations									
	,								
	SECTION V	- DENTAL EXAMINATIO	N AND RECOMMENDATIONS (OPTI-	ONAL)					
have examined chil	d's name	s-teeth	As-a-result-of-this-examination, my-recommendatio	on for treatment is:					
					·····				
	Dentist's Signature								
			AN'S SIGNATURE						
		PHISICIA	AN O OIGNALONE						
Examiner's Signatui		. Date	Examiner's Name (Print		Degree or License				
Number & Street			City ZIF	P 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 Departments of Human Services, Education, Community Health, 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.