



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

FULL DAY:

Summit Academy 3 Year Old Preschool

Enrollment Application
2018-2019 School Year

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

Received: BC Imm. HA DL Deposit

STUDENT INFORMATION

ALL STUDENT NAME FIELDS **MUST** BE AS THEY APPEAR ON THE BIRTH CERTIFICATE

First Name _____ Middle Name _____ Last Name _____ Suffix _____

*****PRESCHOOL STUDENTS MUST BE 3 BY SEPTEMBER 1ST OF THIS YEAR.**

Address _____ City _____ State _____ Zip _____ Phone _____ (_____) _____

Date of Birth _____/_____/_____ Gender _____ Place of Birth _____ School District of Residence _____

DISCIPLINE

Did you withdraw from another school to avoid discipline charges or consequences? YES NO

If so, what was the violation?

PRIMARY CONTACT PARENT/GUARDIAN INFORMATION

Relationship _____ First Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____ Home Phone _____

Work Phone _____ Cell Phone _____ Email Address _____

****ARE THERE CUSTODY ISSUES THE SCHOOL SHOULD KNOW ABOUT? YES NO**

SECONDARY CONTACT PARENT/GUARDIAN INFORMATION

Relationship _____ First Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____ Home Phone _____ (_____) _____

Work Phone _____ Cell Phone _____ Email Address (used for school notification system) _____

EMERGENCY CONTACT INFORMATION
(In addition to Parents/Guardians)

My child may be released to the following people:

Relationship	Name	Home	/ Cell	/ Work
Relationship	Name	Home	/ Cell	/ Work
Relationship	Name	Home	/ Cell	/ Work

STUDENT HEALTH INFORMATION

Is your child subject to condition which may cause emergencies such as epilepsy, diabetes, fainting, allergies, etc.?
Yes No If yes, please explain:

Does your child have any visual or hearing problems for which the school should compensate by seating or other action?
Yes No If yes, please explain:

Does your child have any health conditions which may limit participation in strenuous activities such as physical education or athletics? Yes No If yes, please explain:

Does your child have any other health conditions or medications which should be brought to the schools attention?
Yes No If yes, please explain:

Has your child had chicken pox? Yes No

PHOTO RELEASE

Summit Academy North **DOES NOT** have my permission to use a likeness or photograph of my child. Please check only if you **DO NOT** want your child to be used in any Summit Academy advertisement, newsletter or on the website.

SIBLING INFORMATION

Relationship	Name	School Site	Grade
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Relationship	Name	School Site	Grade
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Relationship	Name	School Site	Grade
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SIGNATURE

- **Payments are due on Mondays.**
- **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.**
- **You DO NOT pay for the Christmas Break or Spring Break.**

To the best of my knowledge the information on this application is true.

Parent/Guardian Signature

____/____/____
Date

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 _____ Grade _____

Student Name _____ D.O.B _____

Address _____

City _____ State _____ Zip _____

Home Number _____

Mother, guardian, step mother, or mother figure (*Circle one*)

Name _____

Address (if different from child's) _____

City _____ State _____ Zip _____

Home Phone _____

Work phone _____

Cell phone _____

Father, guardian, step father or father figure (*Circle one*)

Name _____

Address (if different from child's) _____

City _____ State _____ Zip _____

Home Phone _____

Work Phone _____

Cell phone _____

Student lives with _____

Medications your child takes daily _____

Medical conditions we should be aware of (such as asthma)

Allergies

I have a custody concern.

(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 _____

PLEASE KEEP THIS INFO UPDATED

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

SECTION I - HEALTH HISTORY

	Yes	No	Resolved	# Is your child having any of the problems listed below?		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		1 Allergies or Reactions (for example, food, medication or other)	Birth History: Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: If yes, list medications: Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		2 Hay Fever, Asthma, or Wheezing		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		3 Eczema or Frequent Skin Rashes		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		4 Convulsions/Seizures		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		5 Heart Trouble		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		6 Diabetes		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		7 Frequent Colds, Sore Throats, Earaches (4 or more per year)		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		8 Trouble with Passing Urine or Bowel Movements		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		9 Shortness of Breath		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		10 Speech Problems		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		11 Menstrual Problems		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		12 Dental Problems: Date of Last Exam / /		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Other (please describe): _____		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Does your child take any medication(s) regularly?	If yes, list medications: Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____	
				Reason for Medication		
				/ /	If yes, list medications: Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____	
				Parent/Guardian Signature		
				Date	If yes, list medications: Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> 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
<input type="checkbox"/>	<input type="checkbox"/>	VISION	Visual Acuity				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT	Height			
		Date: / /	Muscle Imbalance				<input type="checkbox"/>	<input type="checkbox"/>	Other:	Weight			
			Other:				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT	Other			
<input type="checkbox"/>	<input type="checkbox"/>	HEARING	Audiometer				<input type="checkbox"/>	<input type="checkbox"/>	BLOOD PRESSURE	Reading: _____			
		Date: / /	Other:				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN	Type: _____			
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS	Sugar				<input type="checkbox"/>	<input type="checkbox"/>		Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm			
		Date: / /	Albumin										
			Microscopic										
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL	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.						
		Date: / /											

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		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (Hep B)	1	3	Hepatitis A (Hep A)	1	2
	2			2	3
DTaP/DTP/DT/Td	1	4	Influenza (TIV/LAIV)	1	3
	2	5		2	4
	3	6	Meningococcal (MCV4 / MPSV4)	1	2
Tdap	1		Human Papillomavirus (HPV4/HPV2)	1	3
Haemophilus Influenzae type b (HIB)	1	3		2	
	2	4	OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
Polio (IPV/OPV)	1	3		1	
	2	4		2	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	3		
	2	4	<i>Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable</i>		
Rotavirus (RV1/RV5)	1	3	*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 child's school or local health department.		
	2		Parent/Guardian refused immunizations: <input type="checkbox"/>		
Measles, Mumps, Rubella (MMR)	1	2			
Varicella (Chickenpox)	1	2			
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date:					
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				
<input type="checkbox"/>	<input type="checkbox"/>	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:			
<input type="checkbox"/>	<input type="checkbox"/>	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> 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 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.