SUMMIT
ACADEMY SCHOOLS

Summit Academy 4 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 4 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
4 Year Old Preschool
Enrollment Application
2018-2019 School Year

*$35 flat rate per week/Class
*$125 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 4 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

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
Relationship	Name	School Site	Grade
Relationship	Name	School Site	Grade

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) 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

_____ / /
Parent/Guardian Signature Date

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?
☐ 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 (Hep B)	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 (Hep A)	1	2
Influenza (TIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (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 child's school or local health department.

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.

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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.