DOCUMENTATION NEEDED FOR ENROLLMENT

Completed enrollment packet

Certified copy of birth certificate

Immunization record

Three proofs of Roseville residency
Driver license/State ID,
Utility Bill DTE or/and Consumers or Utility Application,
Lease or Rental Agreement or Closing Documents,
Tax Bill, or Voter Registration

Or (Affidavit in lieu of above proofs)

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Roseville Community Schools Building _____ Rev. 7/24

Today's Date_____ Start Date_____School Year _____

□ New Enrollee □ Re-Enrollee □ Transfer within district □ School of Choice

SPECIAL HELP

Has your child ever received special education services?	□ Yes	□ No
Does your child have a current IEP?	□ Yes	□ No
Has your child received Title I (Remedial) services?	□ Yes	□ No
Is your child currently on a 504 Plan?	□ Yes	□ No

(Initials of staff member obtaining this information_____)

STUDENT INFORMATION

Legal Last Name_____First Name_____Middle_____

Address_____City_____Zip Code _____

Home Phone ( )_____Grade_____Birth Date _____

□ Male □ Female City of Birth_____Previous School_____

City_____State_____Phone Number ( ) _____

Ethnicity (choose one)
- □ Hispanic or Latino
- □ Not Hispanic or Latino

Race (choose one or more, regardless of ethnicity)
- □ American Indian or Alaska Native
- □ Asian
- □ Black or African American
- □ Native Hawaiian or Other Pacific Islander
- □ White

PARENT INFORMATION– ONLY PARENT/GUARDIAN MAY ENROLL STUDENT

Name of parents/guardians with whom student resides– include last name if different from student.

Name_____ Name_____

Relationship to student_____ Relationship to student _____

Court appointed guardian? □Yes □No Court appointed guardian? □Yes □No

Cell Phone ( )_____ Cell Phone ( )_____

Work Phone ( )_____ Work Phone ( ) _____

E-Mail _____ E-Mail_____

PARENTS LIVING ELSEWHERE (DIVORCED PARENTS) SEND MAIL? □ Yes □ No

Name_____ Relationship to student _____

Address_____City_____Zip Code _____

Home Phone ( )_____Cell Phone ( )_____Work Phone ( ) _____

□ PS □ MCIR □ RR □ MSDS

MEDICAL CONDITIONS/ALLERGIES:

_____

_____

Does your child take medication for this condition? □ Yes □ No
If yes, name of medication _____

If your child will need to take medication at school, please ask for a district Medication Form, which must be completed by your child's doctor.

LIST OTHER CHILDREN IN FAMILY:

Last Name	First Name	Sex	Birthdate	Grade	School he/she will attend

LANGUAGE SPOKEN IN THE HOME

Is your child's native tongue English? □ Yes □ No

Is the primary language used in your child's home or environment English? □ Yes □ No

If no, what is that language? _____

MCKINNEY-VENTO ACT

Is your family living in any of the following situations? Please circle Y (yes) or N (no)

In a motel, camp, or shelter due to the lack of alternative adequate accommodations? **Y N**

In a car, park, abandoned building or bus or train station? **Y N**

Doubled up with other people due to loss of housing or economic hardship? **Y N**

If you answer yes to any of the above questions, your child may be eligible for special services. Our homeless liaison will contact you.

VERIFICATION OF INFORMATION-the undersigned acknowledges that the information provided on this form is true and accurate.

_____ _____

Parent/Legal Guardian Signature **Date**

FOR SCHOOL USE ONLY

TEACHER _____ STREET CODE _____ CENSUS CODE _____ BUS ROUTE _____

VERIFICATION:

□ BIRTH CERTIFICATE □RESIDENCY □ IMMUNIZATIONS □ RECORDS REQUESTED

□ HEARING/VISION SCREENING (KDG.) □ VARICELLA □ CUSTODY PAPERS (IF APPLICABLE)

EXIT INFORMATION:

Exit Date_____ Next Building _____

ROSEVILLE COMMUNITY SCHOOLS
Roseville, Michigan

Permission to Release Permanent School Record to Roseville Community Schools

Please send to the school listed below, all available school records of the following student(s) who is/are enrolling in the Roseville Community Schools.
(MICHIGAN SCHOOLS - please include the student's UIC number.)

PLEASE NOTIFY THE NEW SCHOOL IMMEDIATELY IF STUDENT HAS BEEN EXPELLED.

Student's Name	Birthdate	Grade	Name of School

Include all information you have: District name, address, phone number, fax number

____ Yes ____ No Has this student ever been expelled?

Student's Name	Birthdate	Grade	Name of School

Include all information you have: District name, address, phone number, fax number

____ Yes ____ No Has this student ever been expelled?

I grant permission to the Roseville Community School System to obtain all school records of my child/children named above. I understand that I will have the opportunity to review the records after they arrive if I wish, in order to insure that the contents are accurate. I also understand that I may receive a copy of the school records to be transferred if I desire to do so.

Date of Request	Parent's/Guardian's Signature
Date records received by Roseville Community Schools	Relationship

Send Records to:

Elementary School

Phone: Fax:

Rev. 4/1/24

Administration Building
18975 Church Street
Roseville, MI 48066
586-445-5510 – Phone
586-445-5590 – FAX

AFFIRMATION OF PRIOR DISCIPLINE

Student's Name		
Previous School	**Previous District**	**Phone# of Previous School**
Address of Previous School		**Fax# of Previous School**

***Parent/Guardian* – Check the applicable paragraph; provide all appropriate information and sign this document.**
A willful false statement on this affirmation may result in removal from Roseville Community Schools.

1. _____	The undersigned affirms that the student above **HAS NOT** been suspended from any public or private school in Michigan or any other state within the last two (2) years.
2. _____	The undersigned affirms that the student above **HAS NOT** been expelled from any public or private school in Michigan or any other state.
3. _____	The undersigned affirms that the student above **HAS** been suspended from a public or private school in Michigan or any other state within the last two (2) years.
4. _____	The undersigned affirms that the student **HAS** been expelled from a public or private school in Michigan or any other state.

If you checked number 3 or 4 above, explain the circumstances in detail. Include the school name, date(s) of suspension or expulsion, and a description of the incident giving rise to the suspension or expulsion. Use back, if needed.

_____

_____

Date(s) of suspension or expulsion: From _____ to _____

***Parent/Guardian* – Answer the following statements concerning off-campus misconduct and/or conduct resulting in long-term suspension or expulsion in other school districts:**

Has the student been convicted of a crime, or are any felony charges pending against the student? If the answer is yes, please explain (use separate sheet, if necessary).	YES_____	NO_____
Has the student been expelled or received a long-term suspension (more than 10 days) from another school district? If the answer is yes, please explain (use separate sheet, if necessary).	YES_____	NO_____
Has the student withdrawn from a school district in lieu of being charged with conduct which may have resulted in expulsion or long-term suspension? If the answer is yes, please explain - (use separate sheet, if necessary).	YES_____	NO_____

_____ _____

Parent/Guardian Signature (Student signature if 18 years or older **Date**

PREVIOUS SCHOOL – Please complete the information below:

Name of Former School District: _____

PLEASE INITIAL ALL THAT APPLY:

_____The statements above **are** accurate

_____ The statements above **are NOT** accurate

_____ Student **receives** Special Education Services

_____Student **does not receive** Special Education Services

_____

_____

Verified by: _____ **Title:** _____

PLEASE FAX TO: 586-445-5590

Requested by: _____**Title:** _____**Date:**_____

Revised February 2020

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.