Belding Area Schools

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ELLIS ELEMENTARY SCHOOL

KINDERGARTEN ENROLLMENT CHECKLIST

Student Name: _____

Grade Entering: _____ Enrollment Date: _____

To enroll your child at Ellis Elementary, we require the following documents:

_____ Birth Certificate – Certified original birth certificate with the raised seal. We cannot accept a copy of a birth certificate.

_____ Immunizations – Please review with secretary.

_____ Proof of Residency – Utility bill, lease agreement, property tax bill or purchase agreement. We cannot accept a driver's license as proof of residency.

_____ Proof of Guardianship/Custody – If parents are divorced, a copy of court documentation showing custody responsibility. If guardianship is applicable, documentation must be notarized.

_____ Registration/Emergency Form

_____ Home Language Survey

_____ Student Residency Form – McKinney-Vento

_____ Authorization to Release Records

_____ Prior Discipline Form

_____ Field Trip Permission and Photo/Video Release Form

_____ Transportation Form

_____ Technology Acceptable Use Agreement

_____ Immunization Disclosure Consent Form

_____ Current Transcripts

_____ Special Education Permission to Place (if applicable) – We must have most recent IEP before student can be scheduled into classes

- _____ Section 504 Plan
- _____ Current IEP
- _____ Current MET

_____ Free/Reduced Lunch Application (distributed on the first day of school)

Additional Items Needed for KINDERGARTEN ONLY:

_____ Health Appraisal

_____ Completed Physical Exam Form

_____ Hearing Screening

_____ Vision Screening

100 W. Ellis Avenue • Belding, MI 48809 Phone: 616.794.4100 Fax: 616.794.4142

BELDING AREA SCHOOLS
REGISTRATION/EMERGENCY FORM

Today's Date: _____ 1st Date of Attendance: _____ Entering Grade: _____

Student's Legal Name: _____
Last First Middle

Address: _____
Number/Street Name City State Zip Code County

Birthdate: _____ Birth Place: _____ Gender: ☐ Male ☐ Female
Month/Day/Year City/State/Country

Ethnicity and Race: *(Note: Both Part A and Part B of the question must be answered. If either part (A or B) is not answered, the U.S. Department of Education **requires** the school district to supply an answer on your behalf.)*

Part A: Is this student Hispanic/Latino *(Choose only one)* ☐ No, not Hispanic/Latino ☐ Yes, Hispanic/Latino *(A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)*

Part B: What is the student's race? *(If Multi-Racial, please indicate with percentages)*

____ White (A person having origins in any of the original peoples of *Europe, the Middle East or North Africa)*
____ Black or African American (A person having origins in any of the original peoples of the *Black racial groups of Africa)*
____ American Indian/Alaska Native (A person having origins in any of the original peoples of *North and South American, including Central America)*
____ Native Hawaiian or Other Pacific Islander (A person having origins in any of the original peoples of *Hawaii, Guam, Samoa or other Pacific Islands)*
____ Asian American (A person having origins in any of the original peoples of the *Far East, Southeast Asia, Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam)*

Is your child's native (first) tongue a language other than English? ☐ Yes ☐ No What is the other language? _____

Is the primary language used in your child's home or environment a language other than English? ☐ Yes ☐ No
What is the other language? _____

Where was your child/student born? State _____ Country _____
If your child/student was born outside of the U.S., then when did the child/student enter the country? _____

Previous school attended: _____
District Name City/State

Has your child attended Belding Area Schools before? ☐ Yes ☐ No
Has your child been expelled from school? ☐ Yes ☐ No
If yes, please explain: _____

Special services your child received at previous school: (check all that apply) ☐ McKinney-Vento (Homeless)
☐ Speech ☐ Learning Disabled ☐ Social Worker ☐ Title I ☐ Reading Recovery ☐ Limited English Proficient ☐ Migrant

---

Adult MALE Parent/Guardian in the Home: _____ Relationship: _____

Date of Birth of Adult MALE Parent/Guardian in the Home: _____

Place of Employment: _____ Hours: _____ Work Number: _____

Home Phone Number: _____ Listed: ☐ Yes ☐ No

Cell Number: _____ Email Address: _____

Adult FEMALE Parent/Guardian in the Home: _____ Relationship: _____

Date of Birth of Adult FEMALE Parent/Guardian in the Home: _____

Place of Employment: _____ Hours: _____ Work Number: _____

Home Phone Number: _____ Listed: ☐ Yes ☐ No

Cell Number: _____ Email Address: _____

Other children who reside in the Home:

Legal Name	**Birthdate**	**Grade**	**Building**	
_____	_____	_____	_____	☐ natural sibling ☐ step sibling
_____	_____	_____	_____	☐ natural sibling ☐ step sibling
_____	_____	_____	_____	☐ natural sibling ☐ step sibling

Parent living elsewhere: _____ Home Phone Number: _____ Mailings? ☐ Yes ☐ No

Address: _____
Number/Street Name City State Zip Code

Custody Issues: _____

_____

Emergency Contact Person (Other than Parent)	Phone Number	Relationship
(1) _____	_____	_____
(2) _____	_____	_____
(3) _____	_____	_____
(4) _____	_____	_____

Does your child attend a day care center or go to a sitter after school? ☐ Yes ☐ No

If yes, _____
Number/Street Name City State Zip Code

Emergency medical conditions/problems: (check ALL that apply)

☐ hemophiliac ☐ diabetic ☐ epileptic ☐ asthma ☐ contact lenses ☐ wears glasses
☐ seizures ☐ allergy (please list below)

Other medical conditions that may affect your child at school: _____

_____

Allergies (please list food, medication, and environmental allergies): _____

_____

Medications (please list medications that your child is currently taking): _____

_____

The Family Rights and Privacy Act requires your signature for disclosure of any medical problems your child may have. Your signature will allow release of medical information to school or medical personnel to better serve your child. **If applicable, please provide the school office with a Medical Care Plan signed by your physician.** In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated on this form and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangement necessary. **Note to parents**: No medications will be administered by school personnel without written directions from parent.

Name of Physician: _____ Phone: _____

Physician Address: _____
Number/Street Name City State Zip Code

Parent/Guardian Signature: _____ Date: _____

I have received the fact sheet for parents regarding concussions and understand the district has the responsibility to report all suspected concussions to the parent/guardian.

Parent/Guardian Signature: _____ Date: _____

Have you or a family member worked in agriculture, poultry or dairy in the past three years? ☐ Yes ☐ No
If yes, where did you work? _____ Date: _____
¿A usted o alguien en su familia trabajado en agricultura, una lechería, o con animales como pollos o cerdos en los últimos 3 años?
Si, su respuesta es sí. Cuando _____ y Donde_____.

I affirm, that as the parent/legal guardian, all information provided above is true and accurate, and that my child and I reside at the listed address. I understand any false information provided by me, may subject me to legal penalties for perjury.

Parent/Guardian Signature: _____ Date: _____

Rev. 05/2018

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HOME LANGUAGE SURVEY

Dear Parent or Guardian,

The Belding Area School District is collecting information regarding the language background of each of its students. This information will be used by the district to determine the number of children who should be provided bilingual instruction according to Sections 380.1152 – 380.1157 of the School Code of 1995, Michigan's Bilingual Education Law. Would you please help by providing the following information?

This Home Language Survey has been developed for the purpose of identifying students who may need support in English in order to develop English language proficiency that will allow them to master grade level curriculum. Your child may be given an English language proficiency screener, W-APT, in order to identify their English language proficiency. If the W-APT screener identifies the need for your child to receive ESL services, you will receive a Parent Notification Letter and an explanation of those instructional services.

Thanks you very much for your cooperation.

Student's Name: _____ Grade: _____

Date of Birth: _____ Age: _____

School Building: _____

1. Is your child's native (first) tongue a language other than English?
   ☐ Yes ☐ No What is the other language? _____

2. Is the primary language* used in your child's home or environment a language other than English?
   ☐ Yes ☐ No What is the other language? _____

Parent Name (please print): _____

Parent Signature: _____ Date: _____

Address: _____

*"Primary language" means "the dominant language used by a person for communication."

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ENCUESTA SOBRE EL IDIOMA DEL HOGAR

El Belding Area School District necesita información acerca de le idioma que sus estudiantes hablan o entienden. Esta información sobre su hijo/hija será usada por el distrito escolar para determinar el número de estudiantes que pueden calificar para recibir educación bilingüe de acuerdo a las Secciones 380.1151 – 380.1157 del Código Escolar de 1995, Ley Sobre Educación Bilingüe de Michigan.

Esta encuesta sobre el idioma usado en casa fue hecha con el propósito de identificar a los estudiantes que talvez necesiten ayuda con el idioma inglés para poder dominar el idioma inglés y logar una comprensión completa del vocabulario académico usado en su grado actual. A su hijo/hija se le puede dar un examen de inglés llamado English language proficiency screener o mejor conocido como W-APT para poder demostrar su dominio del idioma inglés. Si el examen W-APT demuestra que su hijo/hija necesita ayuda para dominar el idioma inglés su hijo/hija tendría derecho a recibir apoyo de los servicios de ESL, y usted estaría recibiendo una carta notificándole de estos servicios y explicándole lo que estos servicios son.

Por favor responda a las preguntas que abajo se hacen.
Muchas gracias por su cooperación.

Nombre del estudiante: _____ Grado: _____

Fecha de Nacimiento: _____ Edad: _____

Nombre de su escuela _____

1. ¿Es el idioma nativo[1](primer idioma) de su hijo/hija otro aparte del inglés?

☐ Si ☐ No ☐ ¿Cuál es ese idioma? _____

2. ¿Es el idioma principal[2] usado en la casa o "barrio" de su hijo(a) un idioma diferente al inglés?

☐ Si ☐ No ☐ ¿Cuál es ese idioma? _____

Nombre del padre/madre/guardián (escrito): _____

Firma del padre/madre/guardián: _____ Fecha: _____

Dirección: _____

1 "Idioma nativo" significa "el idioma primero en que el niño/la niña comenzó a entenderse con sus padres.
2 "Idioma principal" significa "el idioma dominante usado por una persona para comunicarse."

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STUDENT RESIDENCY IDENTIFICATION/ELIGIBILTY (SRIE) FORM

By completing this form, you help the district comply with the McKinney-Vento Act, Title X, Part C of the No Child Left Behind Act. Truthful and accurate answers help the district identify services that your student may be eligible to receive.

Building/Grade:_____ Date:_____

Name of person completing form:_____ Relationship to Student:_____

Student's Name:_____ Male/Female: _____ Birth Date:_____

1. Currently living in any of the following situations? (Please check all that apply)

____Sharing the housing of other persons due to:

_____Loss of housing, Economic hardship

_____other(explain):_____

____In Emergency or transitional shelter (explain):_____

____ In a car, park, public place, abandoned building, substandard housing, bus/train station, motel, hotel, campground, or similar setting explain):_____

____Unaccompanied youth (not in physical custody of parent/guardian)

____Living in foster care How long:_____

____NONE OF THE ABOVE*

*If NONE OF THE ABOVE is checked-STOP! Do not complete the remainder of this form.

If any of the other boxes above are checked, additional information is needed. Please complete the remainder of this form. All information will remain confidential.

2. How long have you lived at this location?_____

Address/City/State/Zip_____

Phone number(s): _____ Email:_____

Please list preschool and school aged children currently living at this address:

Name: _____ Birth Date:_____ School:_____

Name: _____ Birth Date:_____ School:_____

Name: _____ Birth Date:_____ School:_____

SCHOOL USE ONLY- Building contact person/Local Liaison determination of eligibility; Based on the above information, I attest to the eligibility for benefits under the McKinney Vento Assistance Act due to the lack of Fixed, Adequate or Regular Residency.

Parent/Guardians/Unaccompanied youth was notified of eligibility on:_____

_____ _____

Signature/Title Date

ELLIS ELEMENTARY SCHOOL

100 W. ELLIS
BELDING, MI 48809
phone 616-794-4100
fax 616-794-4142

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Student Name: _____Birth Date: _____Grade: _____

This is to certify that the parent(s)/ legal guardian of the above named student hereby authorizes and requests:

Previous school district or agency	Address	City	State	Zip

Phone	Fax

to release any pertinent information regarding this child to:

ELLIS ELEMENTARY SCHOOL	100 W. ELLIS	BELDING	MI	48809
School, district, or agency	Address	City	State	Zip

(616)794-4100	(616)794-4142
Phone	Fax

Please fax the following documents ASAP:

_____ Last IEP (if applicable)
_____ Current Transcript
_____ Withdrawal Grades

Please mail the complete school record (CA60) to the following address:

Ellis Elementary School
100 W. Ellis
Belding, MI 48809

Please note: If any of the above referenced information is available only by contacting some other department within your organization, or other agency within your community, please forward, or advise us as to the appropriate mailing address.

_____ _____
Signature of parent/guardian or student (if over 18) Date

In that enclosed education records are being transferred without written consent, any sensitive records such as psychiatric discharge summaries, which could arguably be considered non-educational records, will have been omitted but would be made available upon receipt of signed consent.

FOR OFFICE USE ONLY:

Date Sent: _____ Date Received: _____

ELLIS ELEMENTARY SCHOOL

100 W. Ellis • Belding, Michigan 48809

AFFIRMATION OF PRIOR DISCIPLINE RECORD

A willful false statement on this affirmation will result in a report to the appropriate authorities.

DIRECTIONS: Check the applicable paragraph, provide all appropriate information, and sign this document.

Paragraph 1:

_____ The undersigned affirms that _____ has not been suspended or expelled from any public or private school in Michigan or any other state for an offense involving weapons, alcohol or drugs, or for the willful infliction of injury to another person or for any act of violence against persons and/or property committed on school premises, at any school sponsored activity, or on a public or private conveyance providing transportation to and from a school or school sponsored activity.

Paragraph 2:

_____ The undersigned affirms that _____ has been suspended or expelled from a public or private school in Michigan or another state for one or more offenses involving weapons, alcohol or drugs, or for the willful infliction of injury to another person or for an act of violence against persons and/or property committed on school premises, at any school sponsored activity, or on a public or private conveyance providing transportation to and from a school or school sponsored activity.

If you checked paragraph 2, explain the circumstances in detail. Include the school name, dates of suspension or expulsion, and a description of the incident giving rise to the suspension or expulsion.

_____
_____
_____
_____

Signature of Student: _____ Date _____

Signature of Parent/Guardian: _____ Date _____

Date copy sent for verification: _____ Initials of Belding Area Schools Staff Member: _____

Name of sending (former) school district: _____

Sending School – Please check one:

_____ According to our records, we can verify that the information provided by the parent/student is correct.

_____ According to our records, the information provided above by the parent/student is not correct.

If the student has been involved in offenses involving weapons, alcohol, or drugs, or willful infliction of injury to persons or an act of violence against persons and/or property committed on school premises, at a school sponsored activity, or on a public or private conveyance providing transportation to or from school or a school sponsored activity, please forward appropriate disciplinary documentation.

_____ _____

Date Signature of Sending District Administrator Title

Belding Area Schools

FIELD TRIP PERMISSION

Parents are asked to give permission for their child to go on instructional trips between this date and the end of the school year. With the help of the principal, the classroom teacher will select trips which have educational value. Transportation will be provided by Belding Area Schools. Some field trips may include walking to the destination. Teachers will send home an informational letter letting parents know whenever their class is leaving the building for a trip. Your signed permission will be held on file in the office.

I, _____father/mother/guardian of
(Parent/Guardian name)
_____give permission for my child to
(Child's name)

accompany his/her class on any instructional trips jointly planned and approved by the Principal using transportation provided by bus and/or by walking.

Signature of Parent/Guardian: _____ Date: _____

Telephone: Home: _____ Work: _____

Child's Grade: _____ Homeroom Teacher: _____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated on this form and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangement necessary. **Note to parents**: No medications will be administered by school personnel without written directions from parent.

Physician's Name: _____ **Physician's Telephone #:**_____

Parent/Guardian Signature: _____

I affirm that as the parent/legal guardian, all information provided above is true and accurate. I understand any false information provided by me, may subject me to legal penalties for perjury.

Parent/Guardian Signature: _____ Date _____

****

PHOTO/VIDEO RELEASE FORM

The schools may receive requests to allow students' pictures and video to be taken for use by newspapers, magazines, other publications, television programs, online sites and for a variety of other purposes like school security, student and staff slide and digital media presentations, internal brochures, and district website. For that reason, parent permission is needed on file in our schools. Please sign this release and return with your student.

_____ has my/our permission to have his/her picture and/or video
(Child's name)
taken for any of the above reasons. We understand this consent is ongoing and we will not be contacted further.

Signature of Parent/Guardian: _____ Date: _____

Child's Grade: _____ Homeroom Teacher: _____

Updated: 1/17/2018

Belding Area Schools

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Beverly Brownell • Director • Transportation Department

Transportation Form / New Student

Student Name: _____ Grade: _____

Home Address: _____

City: _____

Parent(s)/Guardian(s): _____

Home Phone: _____ Cell Phone: _____

Emergency Phone: _____ Contact: _____

Thank you for the opportunity to transport the most precious gift there is, your child. If your child is living more than ½ mile from the school they attend, please let us know your needs for transportation for the upcoming school year. **For safety reasons students are allowed one drop-off and one pick-up location.** Parents must be present at the bus stop. If you have any questions, please call us.

Transportation Needs:

___ My child does NOT need transportation provided by school.

___ My child will be picked up and dropped off at the home address listed above or the nearest existing stop.

___ I do not know the place my child will be picked up and/or dropped off. I will let the Transportation Department know by calling 616-794-4970 (open all year), as soon as I have this information.

Daycare Information:

___ My child will be picked up at this location:

Address: _____

Name of childcare provider: _____ Phone: _____

___ My child will be dropped off at this location:

Address: _____

Name of childcare provider: _____ Phone_____

460 E. State St. • Belding, MI 48809 Phone: 616.794.4970 Fax: 616.794.4973

Belding Area Schools

STUDENT TECHNOLOGY ACCEPTABLE USE AND SAFETY AGREEMENT

To access and use District Technology Resources (see definition in Bylaw 0100), including a school-assigned e-mail account and/or the Internet at school, students under the age of eighteen (18) must obtain parent permission and sign and return this form. Students eighteen (18) and over may sign their own forms.

Use of District Technology Resources is a privilege, not a right. The Board of Education's Technology Resources, including its computer network, Internet connection and online educational services/apps, are provided for educational purposes only. Unauthorized and inappropriate use will result in loss of this privilege and/or other disciplinary action.

The Board has implemented technology protection measures that protect against (e.g., block/filter) Internet access to visual displays/depictions/materials that are obscene, constitute child pornography, or are harmful to minors. The Board also monitors online activity of students in an effort to restrict access to child pornography and other material that is obscene, objectionable, inappropriate and/or harmful to minors. Nevertheless, parents/guardians are advised that determined users may be able to gain access to information, communication, and/or services on the Internet that the Board has not authorized for educational purposes and/or that they and/or their parents/guardians may find inappropriate, offensive, objectionable or controversial. Students using District Technology Resources are personally responsible and liable, both civilly and criminally, for unauthorized or inappropriate use of the Resources.

The Board has the right, at any time, to access, monitor, review and inspect any directories, files and/or messages residing on or sent using District Technology Resources. Messages relating to or in support of illegal activities will be reported to the appropriate authorities. Individual users have no expectation of privacy related to their use of District Technology Resources.

Please complete the following information:

Student's Full Name (please print): _____ Grade: _____

Parent/Guardian's Name: _____

Parent/Guardian

As the parent/guardian of this student, I have read the Student Technology Acceptable Use and Safety Policy and Guidelines, and have discussed them with my child. I understand that student access to the Internet is designed for educational purposes and that the Board has taken available precautions to restrict and/or control student access to material on the Internet that is obscene, objectionable, inappropriate and/or harmful to minors. However, I recognize that it is impossible for the Board to restrict access to all objectionable and/or controversial materials that may be found on the Internet. I will not hold the Board (or any of its employees, administrators or officers) responsible for materials my child may acquire or come in contact with while on the Internet. Additionally, I accept responsibility for communicating to my child guidance concerning his/her acceptable use of the Internet - i.e., setting and conveying standards for my daughter/son to follow when selecting, sharing and exploring information and resources on the Internet. I further understand that individuals and families may be liable for violations.

I authorize the District to consent to the sharing of information about my child to website operators as necessary to enable my child to participate in any program, course, or assignment requiring such consent under the Children's Online Privacy Protection Act.

Parent/Guardian's Signature: _____ Date: _____

Student

I have read and agree to abide by the Student Technology Acceptable Use and Safety Policy and Guidelines. I understand that any violation of the terms and conditions set forth in the Policy and Guidelines is inappropriate and may constitute a criminal offense and/or may result in disciplinary action. As a user of District Technology Resources, I agree to communicate over the Internet and through the Technology Resources in an appropriate manner, honoring all relevant laws, restrictions and guidelines.

Student's Signature: _____ Date: _____

Teachers and building principals are responsible for determining what is unauthorized or inappropriate use. The principal may deny, revoke or suspend access to and use of the Technology Resources to individuals who violate the Board's Student Technology Acceptable Use and Safety Policy and related Guidelines, and take such other disciplinary action as is appropriate pursuant to the Student Code of Conduct.

Belding Area Schools

The right size. The right choice.

Vision: All students who graduate from Belding Area Schools will be career and college ready.

Brent R. Noskey • Superintendent

Consent for Disclosure of Immunization Information To Local and State Health Departments

Immunizations are an important part of keeping our children healthy. Schools and state and local health departments must monitor immunization levels to ensure that all communities are protected from potentially life-threatening diseases and, if necessary, respond promptly to an emerging public health threat. It is important that disease threats be minimized through the monitoring of students being immunized.

Sharing immunization and personally identifiable information including the student's name, date of birth, gender and address with local and state health departments will help to keep your child safe from vaccine preventable diseases. The Family Educational Rights and Privacy Act (FERPA) requires written parental consent before personally identifiable information from your child's education records is disclosed to the health department. If your child is 18 or over, he or she is an "eligible student" and must provide consent for disclosure of information from his or her education records.

You may withdraw your consent to share this information in writing at any time.

I authorize Belding Area Schools to release my child's immunization record to the Michigan Department of Health and Human Services and Local Health Department. I understand this information will be used to improve the quality and timeliness of immunization services and to help schools comply with Michigan Law. This includes any information and limited personally identifiable information from the school.

Student's name: _____ Date of Birth: _____

_____ Date: _____

Signature of Parent/Guardian or Eligible Student

_____

Printed Parent/Guardian Name

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:

_____ / /

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
☐	☐	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.

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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.

FREE **Immunization Clinics** **FREE**
Hearing and Vision Clinics

Free Immunization, Hearing and Vision Clinics
are routinely held at local health departments.
Please call to schedule an appointment and make sure you are eligible.

Take your child's immunization record with you to the clinic.

Ionia County Health Department Clinic

www.ioniacounty.org/health-department

Ionia Clinic 175 E. Adams Street (616) 527-5341

Hearing and Vision Clinic: (by appointment only)
3rd Friday of each month

Immunization Clinic: (by appointment only)
Monday, Tuesday, Thursday & Friday 9:00 a.m. – 11:30 a.m. & 1:00 p.m. – 4:00 p.m.
Wednesday 1:00 p.m. – 7:00 p.m.

Mid-Michigan District Health Department Clinic

www.mmdhd.org

Stanton Clinic 615 N. State Road (989) 831-5237

Hearing and Vision Clinic –by appointment only - call (989) 831-3644

Immunization Clinic:
1st, 2nd, 4th Wednesday of the month 8:00 a.m. – 12:00 p.m. & 1:00 p.m. – 5:00 p.m.
3rd Wednesday of the month 9:00 a.m. – 12:00 p.m. & 2:00 p.m. – 6:00 p.m.

Rev. Feb 2017

How to Get Your Child's Birth Certificate

Birth certificates can be obtained from the Clerk's office of the county where your child was born or from the Michigan Department of Community Health. Instructions for obtaining the birth certificate in person, on-line or by mail are available by contacting the appropriate office.

Ionia County Clerk ***$10.00/5.00**
Janae K. Cooper
100 W Main Street
Ionia, MI 48846
(616) 527-5322
FAX: (616)527-8201
http://www.ioniacounty.org/county-clerk/birth-records

Kent County Clerk ***$10.00/3.00**
Lisa Posthumus Lyons
300 Monroe Avenue NW
Grand Rapids, MI 49503-2288
(616) 632-7640
FAX: (616) 632-7645
https://www.accesskent.com/Departments/CountyClerk/birth.htm

Montcalm County Clerk ***$25.00/5.00**
Kristen Millard
211 W Main Street
PO Box 368
Stanton, MI 48888
(989) 831-7339
FAX: (989) 831-7474
http://www.montcalm.us/government/county_clerk/birth_certificate_information.php

Michigan Department of Community Health ***$46.00/16.00**
Vital Records Requests
P.O. Box 30721
Lansing, MI 48909
(517) 335-8666, option #4
FAX: (517) 321-5884
http://www.michigan.gov/mdhhs/0,5885,7-339-71551_4645---,00.html

*The first amount is for one copy and the second amount is for each additional copy.

Please note:

- Your name must appear on the birth certificate in order to request additional copies.
- If there is no father listed on the birth certificate, you will need to request the record from Michigan Department of Community Health.

Belding Area Schools

The right size. The right choice.

Directory Information

Each year the Superintendent shall provide public notice to students and their parents of the District's intent to make available, upon request, certain information known as "directory information." The Board designates student "directory information" as:

A. a student's name;
B. major field of study;
C. participation in officially recognized activities and sports;
D. height and/or weight, if a member of an athletic team which requires disclosure to participate;
E. awards received;
F. grade placement;
G. honor rolls;
H. scholarships;
I. school photographs or videos of students participating in school activities, events or programs.

The District commonly uses student directory information for the following purposes:

A. School yearbook
B. Programs for athletic events, musical/drama presentations, graduation and/or award ceremonies
C. Academic Honor Roll recognition
D. School and/or district newsletters
E. School and/or district web site/social media
F. Project Graduation

Parents may elect not to have his/her child's directory information disclosed for one or more of the listed uses by completing the opt-out form below and returning it to the child's school within the first 30 days of the school year. This form is also available at the school office.

Directory Information Opt-Out Form

Student Name: _____ School Year: _____

School Name: _____ Grade: _____

I request that my child's directory information not be included in publications listed below:

_____

_____

Parent Signature: _____ Date: _____

HEADS UP SCHOOLS

A Fact Sheet for Parents

What is a concussion?

A concussion is a type of brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head. Concussions can also occur from a blow to the body that causes the head and brain to move rapidly back and forth. Even what seems to be a mild bump to the head can be serious.

Concussions can have a more serious effect on a young, developing brain and need to be addressed correctly.

What are the signs and symptoms of a concussion?

You can't see a concussion. Signs and symptoms of concussion can show up right after an injury or may not appear or be noticed until hours or days after the injury. It is important to watch for changes in how your child or teen is acting or feeling, if symptoms are getting worse, or if s/he just "doesn't feel right." Most concussions occur without loss of consciousness.

If your child or teen reports ***one or more*** of the symptoms of concussion listed below, or if you notice the symptoms yourself, seek medical attention right away. Children and teens are among those at greatest risk for concussion.

SIGNS AND SYMPTOMS OF A CONCUSSION

SIGNS OBSERVED BY PARENTS OR GUARDIANS

- Appears dazed or stunned
- Is confused about events
- Answers questions slowly
- Repeats questions
- Can't recall events *prior* to the hit, bump, or fall
- Can't recall events *after* the hit, bump, or fall
- Loses consciousness (even briefly)
- Shows behavior or personality changes
- Forgets class schedule or assignments

SYMPTOMS REPORTED BY YOUR CHILD OR TEEN

Thinking/Remembering:
- Difficulty thinking clearly
- Difficulty concentrating or remembering
- Feeling more slowed down
- Feeling sluggish, hazy, foggy, or groggy

Physical:
- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Fatigue or feeling tired
- Blurry or double vision
- Sensitivity to light or noise
- Numbness or tingling
- Does not "feel right"

Emotional:
- Irritable
- Sad
- More emotional than usual
- Nervous

Sleep*:
- Drowsy
- Sleeps *less* than usual
- Sleeps *more* than usual
- Has trouble falling asleep

**Only ask about sleep symptoms if the injury occurred on a prior day.*

To download this fact sheet in Spanish, please visit: www.cdc.gov/Concussion. Para obtener una copia electrónica de esta hoja de información en español, por favor visite: www.cdc.gov/Concussion.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

May 2010

DANGER SIGNS

Be alert for symptoms that worsen over time. Your child or teen should be seen in an emergency department right away if s/he has:

- One pupil (the black part in the middle of the eye) larger than the other
- Drowsiness or cannot be awakened
- A headache that gets worse and does not go away
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Difficulty recognizing people or places
- Increasing confusion, restlessness, or agitation
- Unusual behavior
- Loss of consciousness (even a brief loss of consciousness should be taken seriously)

Children and teens with a concussion should NEVER return to sports or recreation activities on the same day the injury occurred. They should delay returning to their activities until a health care professional experienced in evaluating for concussion says they are symptom-free and it's OK to return to play. This means, until permitted, not returning to:

- **Physical Education (PE) class,**
- **Sports practices or games, or**
- **Physical activity at recess.**

What should I do if my child or teen has a concussion?

1. **Seek medical attention right away.** A health care professional experienced in evaluating for concussion can determine how serious the concussion is and when it is safe for your child or teen to return to normal activities, including physical activity and school (concentration and learning activities).
2. **Help them take time to get better.** If your child or teen has a concussion, her or his brain needs time to heal. Your child or teen may need to limit activities while s/he is recovering from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games may cause concussion symptoms (such as headache or tiredness) to reappear or get worse. After a concussion, physical and cognitive activities—such as concentration and learning—should be carefully managed and monitored by a health care professional.
3. **Together with your child or teen, learn more about concussions.** Talk about the potential long-term effects of concussion and the dangers of returning too soon to normal activities (especially physical activity and learning/concentration). For more information about concussion and free resources, visit: www.cdc.gov/Concussion.

How can I help my child return to school safely after a concussion?

Help your child or teen get needed support when returning to school after a concussion. Talk with your child's teachers, school nurse, coach, speech-language pathologist, or counselor about your child's concussion and symptoms. Your child may feel frustrated, sad, and even angry because s/he cannot return to recreation and sports right away, or cannot keep up with schoolwork. Your child may also feel isolated from peers and social networks. Talk often with your child about these issues and offer your support and encouragement. As your child's symptoms decrease, the extra help or support can be removed gradually. Children and teens who return to school after a concussion may need to:

- Take rest breaks as needed,
- Spend fewer hours at school,
- Be given more time to take tests or complete assignments,
- Receive help with schoolwork, and/or
- Reduce time spent reading, writing, or on the computer.

*To learn more about concussion and to order materials **FREE-OF-CHARGE**, go to: **www.cdc.gov/Concussion** or call **1.800.CDC.INFO**.