Rogers City Area Schools
Rogers City Elementary School
532 West Erie Avenue
Rogers City, Michigan 49779
PH: (989) 734-9150 FAX: (989) 734-9165

ENROLLMENT INFORMATION

Documentation required for enrollment in Rogers City Area Schools is listed below. Documentation must be received prior to the first day attending school.

- ☐ **Rogers City Area Schools' Application for Enrollment**
- ☐ **Child's original certified birth certificate,** as required by state law
- ☐ **Proof of residency** – we will accept only the documents listed below as proof of residency
  - Parent/guardian driver's license with current address, or
  - Current lease/rental agreement and a current utility/telephone bill
- ☐ **Parent/guardian picture identification**
- ☐ **Immunization records**
- ☐ **Vision, hearing & dental screening results,** as required by state law
- ☐ **Guardianship/custody order**, if applicable -If there are custody restrictions on a divorce decree or court order, please bring that documentation with you at the time of enrollment.

Your child is not officially enrolled and may not attend school until all of the required documentation has been submitted.

Rogers City Area Schools Board of Education Policies and our school handbook may be reviewed at our school website at www.rcas.k12.mi.us or by contacting the school office.

Kindergarten Enrollment:

A child is eligible for kindergarten if he or she will be 5 years of age on or before September 1st of the upcoming school year.

Your kindergarten registration appointment is scheduled for
Date:_____Time:_____

Please complete and return enrollment forms prior to your scheduled registration day or plan to arrive 15 minutes early on the day of your appointment.

Rogers City Area Schools

1033 West Huron Avenue, Suite B, Rogers City, MI 49779

Enrollment Application

Student Legal Information

First: _____ Middle: _____ Last: _____

Birthdate: _____ Age: _____ City/State of Birth: _____

Gender: ☐ Male ☐ Female Grade enrolling in: _____ Previously enrolled in Rogers City Area Schools: ☐ Yes ☐ No

Student's Primary Residence

Address: _____ Apt #: _____ City: _____ Zip: _____

Primary Phone Number: _____ **Busing Requested: ☐ Yes ☐ No**

Student Lives With: (Please check) ☐ Both natural parents ☐ Father ☐ Mother ☐ Relative ☐ Legal guardian ☐ Foster ☐ Other (explain) _____

If student does not live with both natural parents, custody order must be provided to school.

Mother Legal Name			Father Legal Name		
Maiden Name					
Home Address			Home Address		
Home Phone #			Home Phone #		
Marital Status			Marital Status		
Lives with Student?	☐ Yes	☐ No	Lives with Student?	☐ Yes	☐ No
Employer			Employer		
Work #			Work #		
Cell #			Cell #		
Email			Email		

Please complete Stepmother/Stepfather information if applicable:

Stepmother Name			Stepfather Name		
Lives with Student?	☐ Yes	☐ No	Lives with Student?	☐ Yes	☐ No
Employer			Employer		
Work #			Work #		
Cell #			Cell #		

Guardian/Foster Caregiver Name: **Address:** **Phone:**

Student's Ethnic and Language Information

Part A: Is the student of Hispanic/Latin Descent? ☐ Yes ☐ No

(A person of Cuban, Mexican, Puerto Rican, South or Central America or other Spanich origin regarless of race)

Part B: Student's Race (choose one or more) ☐ American Indian or Alaskan ☐ Caucasion ☐ Asian ☐ Arab American ☐ African American/Black ☐ Native Hawaiian/Pacific Islander

Both parts A and B must be completed. We encourage you to select an answer for both parts. If either part is not completed, the US Dept. of Education requires the school district to supply an answer on your behalf.

Student's Primary Language: English ☐ Yes ☐ No If no, what language is primary? _____

Previous School Information (Please list last school attended including pre-kindergarten)

Name: _____ Last Day: _____ Year(s) Attended: _____ Grade(s): _____

Address: _____ City/State: _____

Is there a current IEP for Special Education Services or 504 Plan: ☐ Yes ☐ No

If yes, for what services? _____

Has the student had a suspension or expulsion from any school district: ☐ Yes ☐ No

Please continue to page 2 of this Enrollment Application

Rogers City Area Schools

1033 West Huron Avenue, Suite B, Rogers City, MI 49779

Enrollment Application - Page 2

Student Name: _____ Today's Date: _____

Sibling Information

Name: _____ Birthdate: _____ School attending: _____

_____ _____ _____

Additional Student Information

Student is living in a household with a person who has served or is serving in the military. ☐ Yes ☐ No

Name of military personnel: _____

Student Residence is: (please check one)

_____ Single family in a house or dwelling

_____ Hotel/Motel

_____ Shelter

_____ Unsheltered

_____ More than one family in a house or dwelling

_____ Transitional housing or other (please describe)

_____ Lives with friend or relative, other than parents or guardians

Medical Information

Allergies: _____

Medications: _____

Parent/Guardian Information and Authorization

In case of emergency, I hereby authorize school officials to provide first aid and/or seek medical treatment from emergency services. The parent(s)/guardian(s) are responsible for all expenses incurred. My signature below authorizes emergency medical care for my child and release of medical condition(s) to school administration personnel. **Parent/Guardian Signature:** _____ Date: _____

I have provided my child's original certified birth certificate.

Parent/Guardian Signature: _____ Date: _____

I am not able to produce a certified birth certificate for the following reasons: _____

I am able to provide reliable proof of my student's identity and age with the following documents:

_____ Baptismal Certificate Other _____

_____ Court Records

_____ Passport or Immigration Record

Parent/Guardian Signature: _____ Date: _____

I verify that all statements made in this application are true and accurate. I understand that if at any time a misrepresentation of these facts is discovered, my child will be released immediately to his/her home school, or the undersigned agrees to accept responsibility for full payment of tuition, at the state per pupil foundation rate. I also give permission for Rogers City Area Schools to contact previous school(s) for verification of information included in this application. I have been informed of my rights under FERPA.

Parent/Guardian Signature: _____ Date: _____

Office Use Only: Birth Cert: Immun: Lic: SOC: IEP: SE:

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 (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	
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 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 _____ (child's name)'s teeth. As a result of this examination, my recommendation for treatment is: _____

_____

_____ ___/___/___

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.

Food Allergy Assessment Form

Student Name:_____ Birth Date:_____ Date:_____

Parent/Guardian Name:_____ Phone:_____

If your child has NO known food allergy, please sign here:

If your child HAS food allergy, please complete the entire form below.

Health Care Provider (name) treating food allergy: _____ Phone:_____

Do you think your child's food allergy may be life-threatening? ❑ No ❑ Yes
(If YES, please see the school nurse as soon as possible).

Did your student's health care provider tell you the food allergy may be life-threatening? ❑ No ❑ Yes
(If YES, please see the school nurse as soon as possible.)

History and Current Status

Check the foods that have caused an allergic reaction:

❑ Peanuts ❑ Fish/shellfish ❑ Eggs
❑ Peanut or nut butter ❑ Soy products ❑ Milk
❑ Peanut or nut oils ❑ Tree nuts (walnuts, almonds, pecans, etc.)
Please list any others: _____

How many times has your student had a reaction? ❑ Never ❑ Once ❑ More than once, explain:_____

When was the last reaction? _____

Are the food allergy reactions: ❑ staying the same ❑ getting worse ❑ getting better

Triggers and Symptoms

What has to happen for your student to react to the problem food(s)? *(Check all that apply)*

❑ Eating foods ❑ Touching foods ❑ Smelling foods ❑ Other, please explain:_____

What are the signs and symptoms of your student's allergic reaction? *(Be specific; include things the student might say.)*

How quickly do the signs and symptoms appear after exposure to the food(s)?

_____ Seconds _____Minutes _____ Hours _____Days

Treatment

Has your student ever needed treatment at a clinic or the hospital for an allergic reaction?

❑ No ❑ Yes, explain:_____

Does your student understand how to avoid foods that cause allergic reactions? ❑ Yes ❑ No

What treatment or medication has your health care provider recommended for use in an allergic reaction?

Have you used the treatment? ❑ No ❑ Yes

Does your student know how to use the treatment? ❑No ❑ Yes
Please describe any side effects or problems your child had in using the suggested treatment:_____
_____
_____

If you intend for your child to eat school provided meals, have you filled out a diet order form for school?

❑ Yes.
❑ No, I need to get the form, have it completed by our health care provider, and return it to school.

If medication is to be available at school, have you filled out a medication form for school?

❑ Yes.
❑ No, I need to get the form, have it completed by our health care provider, and return it to school.

If medication is needed at school, have you brought the medication/treatment supplies to school?

❑ Yes.
❑ No, I need to get the medication/treatment and bring it to school.

What do you want us to do at school to help your student avoid problem foods?_____
_____
_____

I give consent to share, with the classroom, that my child has a life-threatening food allergy.

❑ Yes.
❑ No.

Parent/Guardian Signature:_____ Date: _____

Reviewed by R.N.: _____ Date: _____

Adapted with permission from ESD 171 SNC Program

Rogers City Area School District

Consent for Disclosure of Personally Identifiable Information and 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), 20 U.S.C. § 1232g, requires written parental consent before personally identifiable information and immunization 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 disclosures of information from his or her education records.

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

I authorize *Rogers City Area School District* *to release my child's immunization record and personally identifiable information 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 immunization information and limited personally identifiable information from the school.*

Student's Name: _____ Date of Birth: __/__/__

Signature of Parent/Guardian
or Eligible Student: _____ Date:__/__/__

Printed Parent/Guardian Name: _____

ROGERS CITY AREA SCHOOLS

532 West Erie Avenue, Rogers City, Michigan 49779
(989) 734-9150, fax (989) 734-9165

REQUEST FOR TRANSFER OF STUDENT RECORDS

Rev: 06/18

STUDENT NAME:_____
(Last) **(First)** **(M.Init.)**

DATE OF BIRTH:_____ **GRADE:**_____

SCHOOL LAST ATTENDED:

Name: _____

Address: _____

_____

Phone:_____ Fax:_____

This student has been enrolled at the school listed below. Please send the records of the above student to:

☐ Rogers City Elementary School
Principal's Office
532 W. Erie Avenue
Rogers City, MI 49779

☐ _____

CURRENT SCHOOL WITHDRAWAL DATE:_____
DATE ENTERING NEW SCHOOL:_____

Please include Cumulative Records, Health and Immunization Records, Birth Certificate, Test Scores, Psychological, Psychiatric and/or Emotional Evaluation, etc. These will be for the professional use of authorized Rogers City Area School District personnel only. Any further information you can provide to help in proper placement of the student will be appreciated. Thank you for your prompt cooperation.

MICHIGAN SCHOOLS
Please fax student UIC #

UIC#_____

I am the parent or guardian of the above student and give consent for such information to be sent. I am aware of my right to inspect and obtain copies of any or all records, files and data.

_____ _____
(Date) (Signature of Parent or Legal Guardian)

FEDERAL STATUTE ENTITLED: **Privacy Right of Parents and Students**

Schools may send a student's educational record to officials of other schools or school systems in which the student seeks or intends to enroll, upon condition that the student's parent(s) or guardian(s) be notified of the transfer, receive a copy of the record if desired and have the opportunity to challenge the content of the record.

ROGERS CITY AREA SCHOOLS
1033 W. Huron Avenue, Suite B, Rogers City, MI 49779
(989) 734-9100

Request for Student Transportation by Bus

Transportation between home and school will be provided for each resident child within our established bus routes. The Board of Education reserves the right to terminate transportation based on District financial, legal, or other considerations. It is a privilege for students to ride a District vehicle and this privilege may be revoked if the student's conduct is in violation of the Administrative Guidelines or the Code of Conduct pertaining to student transportation. It is understood that the student will have <u>one</u> primary pick-up and drop-off location as determined by the District. Alternate arrangements on an urgent or emergency basis only may be accommodated if provided in writing to the school office or by contacting the school office. Without notification of this manner, your student will be transported to and from your primary location. ***It is the responsibility of the parent, or guardian to ensure that students are safe and supervised upon drop-off. It is the responsibility of the parent or guardian to notify the school office immediately upon change of address or contact information.***

*Name of Student(s):*_____ *Grade:*_____
*Name of Student(s):*_____ *Grade:*_____
*Name of Student(s):*_____ *Grade:*_____
*Name of Student(s):*_____ *Grade:*_____
Student HOME address:_____
Starting Date:

<u>Primary</u> Pick-up and Drop-off Address:_____

Pick-up Days: Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐
Drop-off Days: Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐

Description of Location (i.e. color of house, closest roads intersecting, etc.):

Name of primary adult(s) at this residence: Relationship to student:
Phone number at residence:

<u>One</u> Alternate Address Approved for Pick-up/Drop-Off:_____

Pick-up Days: Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐
Drop-off Days: Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐

Description of Location (i.e. color of house, closest roads intersecting, etc.):

Name of primary adult(s) at this residence: Relationship to student:
Phone number at residence:

Printed Name of Parent/Guardian(s):_____

Signature:_____ Phone:_____ Date:_____

doc/bus/req for transp

Office Use: ☐ New enroll ☐ Sibling add

Primary Bus Assigned_____ Alternate Bus Assigned_____

Rogers City Area Schools
Application for Schools of Choice
School Year 2024-2025

Student's name: _____ Date of birth: _____

Grade level (entering): _____ Male _____ Female _____ Home phone: _____

Parent's name: _____ Work phone: _____

Address: _____ P.O. Box Number: _____

_____

Other school age children in household: Name _____ Grade _____

Name _____ Grade _____

Name _____ Grade _____

School district of residence: _____

School currently attending: _____

Reason for request: _____

Special Education Services required? _____ yes _____ no	If yes, please explain
Has the student ever been expelled from school for any reason? _____ yes _____ no	If yes, how long & please explain reason for expulsion
Has the student ever been suspended from school for any reason during the past two (2) years? _____ yes _____ no	If yes, please explain
Are all immunizations current? _____ yes _____ no	If no, please explain
Does student have a criminal record? _____ yes _____ no	If yes, state offense: _____ Name of county/court: _____ Sentence: _____
Is student currently under court jurisdiction? _____Yes, on probation. How long? _____	_____ No, not currently on probation

By signing below I agree to hold harmless Rogers City Area Schools district, their employees and the Board of Education members for any decision in the selection process, potential or actual participation as a Section 105 Schools of Choice student relative to academic achievement, co-curricular participation, student discipline related to behavior and all other aspects of participation as a member of a student body.

It is further understood that transportation for non-resident students will be provided by the parent/legal guardian. I also consent to have all student records information (including academic and behavioral records) released to Rogers City Area Schools from the school district previously attended.

I understand that the student may be tested in order to determine proper grade level. I understand that, due to high academic standards of Rogers City Area Schools, some academic credits may not transfer from my student's home district. I understand that, if more students apply for a grade/program than those available, the district will hold a random drawing to determine those students accepted. Finally, I understand that any misrepresentation as part of the application process may result in the dismissal of the student.

_____ _____

Parent or legal guardian signature Date

_____ _____

Student signature, if legal age Date

Central Office use ONLY

Date application received: _____

*Was student a non-resident student of RCAS last year? _____ yes _____ no

*Does applicant have a sibling already attending RCAS? _____ yes _____ no

_____ Application approved

_____ Application denied (reason/comment) _____

_____

_____ _____

Superintendent Date