FOR OFFICE USE ONLY:			
ID #: _____ Enrollment Date: _____ Graduation Year: _____	Res #: _____ Oper #: 71080 HS: 03252	Locker #: _____	☐ Birth Cert. ☐ Immunizations Dropped: _____ Reason: _____

Rogers City Area Schools
ROGERS CITY HIGH / MIDDLE SCHOOL
STUDENT REGISTRATION FORM

Today's Date: **GRADE:** _____

STUDENT INFORMATION:

Last Name: First Name: Middle Name:

Address: City: Zip: Township:

Telephone: Cell Phone: Busing requested: ☐ Yes ☐ No

Birthdate: Birth City: Birth State:

Sex: ☐ Male ☐ Female Age:

Ethnic: ☐ Caucasian ☐ Black ☐ Hispanic ☐ American Indian ☐ Alaska Native

☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Other:_____

Is English the primary language spoken in your home: ☐ Yes ☐ No
If no, what language:_____

Student Residency: (please check one)

____Singe family in a house or dwelling
____More than one family in a house or dwelling
____Lives with friend or relatives--other than parents or guardians
____Hotel/Motel
__ Shelter
__ Unsheltered
__ Transitional housing
__ other (please describe):

SCHOOL LAST ATTENDED:

Name: _____

School Address:_____

City:_____ State:_____ Zip: _____

Telephone:_____ Last day attended:_____

Special Education services received: ☐ Yes ☐ No
If yes, a "Temporary Placement" form must be signed.

Has your child been suspended or expelled by a Principal, Superintendent, Hearing Officer, or Board of Education for a semester or more? ☐ Yes ☐ No
If yes, by whom and for what reason _____

PLEASE COMPLETE INFORMATION ON REVERSE SIDE.

Required Documentation: Original Certified Birth Certificate, Immunization records. Proof of Residency, Parent/Guardian picture identification, Guardianship/custody order if applicable.

BIRTH **PARENT INFORMATION:**		
	MOTHER:	**FATHER:**
Name:	(Maiden)	
Lives with Student:	☐ Yes ☐ No	☐ Yes ☐ No
Country/State of Birth:		
Education Status:		
Occupation:		
Employer Name:		
Employer Address:		
Employer Telephone:		
e-mail address:		
If other than birth parent:	⬇	⬇
Spouse Name:		
Spouse Employer:		
Spouse Employer Address:		
Spouse Employer Phone:		
Cell Phone #:		
LEGAL GUARDIAN WITH WHOM THE STUDENT LIVES:		
Name:		
Occupation:		
Employer Name:		
Employer Address:		
Employer Telephone:		
Cell Phone #:		

NAME OF SIBLINGS:	**Birthdate:**	**School Attending:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMERGENCY CONTACT INFORMATION:

Name:_____ Relationship:_____
Address:_____ Phone:_____
_____ Work Phone:_____

Name:_____ Relationship:_____
Address:_____ Phone:_____
_____ Work Phone:_____

Signature: _____ Relationship: _____
Date: _____

Required Documentation: Original Certified Birth Certificate, Immunization records. Proof of Residency, Parent/Guardian picture identification, Guardianship/custody order if applicable.

☐ NOTICE OF ENROLLMENT IN SPECIAL EDUCATION (FILL OUT **ENTIRE FORM)**

☐ STUDENT ACTIVATION FOR REED PROCESS (FILL IN ***TOP BOX ONLY***)

****YOU MUST SUBMIT A *SIGNED COPY* OF THE ELECTRONIC REED TO THE COP OFFICE UPON COMPLETION OF THIS FORM****

UIC: (Required) _____ Date: _____

Student (PRINT)_____ District of Residence_____ County _____

Case Manager_____ District/Building_____

Birthdate_____ Grade_____ Student's Address_____

Gender ☐M ☐F Ethnic Group_____ City/State/Zip_____

Parent Name **(PRINT)** _____ Parent Telephone _____

Student Residency Information (Check if Applicable) ☐ School of Choice ☐ Home School ☐ Section 53

The school district will provide the student with a free appropriate public education (FAPE) until the current IEP is implemented OR a determination has been made to hold a new IEP within 30 school days from the date of district administrator signature.

PLEASE CHECK ON OPTION BELOW - *NOTE: OPTIONS 1 OR 2 REQUIRE
COP ANCILLARY STAFF / SPECIAL EDUCATION TEACHER / ADMINISTRATOR COLLABORATION

☐ 1) **Student Enrolls from Within a COP District** (i.e. Cheboygan to Inland Lakes)
District Student is FROM: _____
The receiving district has obtained a copy of the last IEP and ***ALL*** Programs/Services to be implemented.
☐ YES, the IEP will be implemented exactly as written.
☐ NO, a TRANSFER IEP will be held by (date)_____ within 30 SCHOOL days.
******** ***Initials of Administrator OR Representative to approve implementation*** _____

☐ 2) **Student Enrolls from District using EasyIEP** **District Student is FROM:** _____
The receiving district has obtained a copy of the last IEP and ***ALL*** Programs/Services to be implemented.
☐ YES, the IEP will be implemented exactly as written.
☐ NO, a TRANSFER IEP will be held by (date)_____ within 30 SCHOOL days.
******** ***Initials of Administrator OR Representative to approve implementation*** _____

☐ 3) **Student Enrolls from District within Michigan** (Not and EASYIEP Student)
A transfer IEP will be held by (date)_____ within 30 SCHOOL days.

☐ 4) **Student Enrolls from a District OUT OF STATE**
IMMEDIATELY forward a copy of this Notice of Enrollment in Special Education Form, most recent IEP AND MET to COPESD. Contact COP Staff to complete **"INITIAL"** REED and MET. **Initial IEP** will be held (date) _____ within 30 SCHOOL days from date of District Administrator signature.

Disability _____ Hours per week placed in Special Education classroom _____

Programs/Services _____ Special Education Teacher_____

COMPLETE HOURS FOR ALL SERVICES THAT APPLY

Number of hours per week per ancillary service(s): SLI_____ OT_____ PT_____
(Appropriate ancillary staff MUST initial here) _____ _____ _____

Number of hours per week per ancillary service(s): SSW _____ TC/VI _____ TC/HI _____
(Appropriate ancillary staff MUST initial here) _____ _____ _____

_____ _____
Parent/Guardian Signature Date

_____ _____
Principal or Administrative Representative Signature Date
******* INITIAL (1) OR (2) ABOVE IF CHECKED *******

Revised 1.18.22

ROGERS CITY HIGH SCHOOL / MIDDLE SCHOOL
Rogers City, MI

Please check below ALL services or conditions that your child received at his/her previous school:

- ☐ Takes medication regularly at school
- ☐ Section 504 Plan
- ☐ Received special education services: *(please circle)*

  LD Speech/Hearing CI EI VI HI

  ASD PI OHI SLI ECDD

- ☐ Homeless
- ☐ Title I
- ☐ Bilingual Services / ELL
- ☐ Migrant Education Services

Has your child been suspended or expelled by a Principal, Superintendent, Hearing Officer, or Board of Education for a semester or more? Yes No
Current Status – Reinstated ☐ Yes ☐ No

If yes, by whom? _____

If yes, for what reason were they suspended/expelled?

_____
_____
_____
_____
_____

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

NEW STUDENT FORM 2025-26 – For students who change schools after starting 9th grade

YES ☐ NO ☐ I AM INTERESTED IN PARTICIPATING IN ATHLETICS

To be completed by new students, parents, and former school. *This form is intended to assist schools in compiling information to determine eligibility under MHSAA Regulations. Provide copies in new student packets and as soon as possible, the form should be submitted to the athletic director for evaluation. The AD may then contact the MHSAA for assistance. Consult Int. 65 and 77 or the Residential Change Check List on MHSAA.com (Schools→ Parents→ Regulations Summary) to assist in determining if residential changes are full and complete.* ***Int. 37 states two current and complete documents are prerequisites for participation: Physical Exam/Consent Form or Health Questionnaire/Consent Form and official school record (transcript) since first enrolling in the 9th grade of any school.***

SECTION COMPLETED BY SCHOOL & STUDENT – CHECK TRANSCRIPT	**- Official enrollment date (in school records & attending one or more classes) →**	
	- Number of classes for which credit has been given in the previous academic term →	
	- Number of potential classes for a full-time student in the previous high school →	
	- Number of semesters and/or trimesters in grades 9-12 COMPLETED to date →	
	- In what school year did the student END the 8th grade (and BEGIN grade 9th) →	
	- Has the student REPEATED any grades 9-12? →	

STUDENT'S NAME _____ GRADE _____ BIRTHDATE _____/_____/_____

PHONE (_____)_____ EMAIL _____

CURRENT (NEW) ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF RESIDENCE CHANGE INTO CURRENT (NEW) ADDRESS _____

CURRENT (NEW) PUBLIC SCHOOL DISTRICT IN WHICH YOU RESIDE _____

NEW ADDRESS IS IN A DIFFERENT PUBLIC SCHOOL DISTRICT (OR ATTENDANCE AREA OF A MULTI-HIGH-SCHOOL DISTRICT) ☐ Y ☐ N

OLD HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

FORMER RESIDENCE (CHECK ALL THAT APPLY) ☐ VACANT ☐ SOLD ☐ RENTED ALL BELONGINGS MOVED? ☐ Y ☐ N

FORMER PUBLIC SCHOOL DISTRICT OF RESIDENCE _____

PARENT(S) OR GUARDIAN(S) _____ PHONE: (_____)_____

1. The last school the student attended _____

2. While enrolled at the former school, the student lived with _____
   ***(List ALL people & their relationship to the student** - parents, siblings, or others)*

   ☐ YES ☐ NO The student lived with the above for at least 30 days during the most recent previous academic term.

3. The student NOW lives with _____
   ***(List ALL people & their relationship to the student** - parents, siblings, or others)*

SELECT THE APPROPRIATE ANSWER

4. 9 10 11 12 Circle the highest grade in which the student was enrolled at any previous school.
5. ☐ YES ☐ NO School previously attended was a nonpublic or charter school.
6. ☐ YES ☐ NO Student is a "Ward of the Court/State" and was placed in this school District by court order.
7. ☐ YES ☐ NO Student is an international student enrolling from a foreign country. **Select VISA**: ☐ F1 ☐ J1

7a. ☐ YES ☐ NO Student is from an MHSAA Approved International Student Program (AISP).
   Program Name: _____ Program is listed on MHSAA.com ☐ Y ☐ N

8. ☐ YES ☐ NO Student's previous school has been closed, dissolved, or reorganized. *(see Int. 64 & 90)*
9. ☐ YES ☐ NO Student's parents are DIVORCED. If divorced, give exact decree date: **Month**____ **Day**____ **Year**_____
10. ☐ YES ☐ NO Student is 18 or under, or the 19th birthday is on or after Sept. 1st of this school year.
11. ☐ YES ☐ NO Last year, the student lived at a boarding school, or while enrolled out of state, attended a sports academy.
12. ☐ YES ☐ NO Student is 18 and moved into this District WITHOUT his or her parents.
13. ☐ YES ☐ NO Student participated in a cooperative program involving his/her previous school and our school.
14. ☐ YES ☐ NO Student wishes to discuss her/her situation with the athletic director.

OVER →

VERIFICATION OF PREVIOUS HIGH SCHOOL SPORTS PARTICIPATION

15. List ALL high school sports the student participated in (game/meet or scrimmage at any level) in the most recent previous school year and, if the transfer occurs after the school year started, list any sports participated in at any level during the current school year. List the year next to the sport played (e.g., 2024-25).

FALL	WINTER	SPRING

16. List the sport(s) in which the student desires to participate in during the next 12 months at the new school:

• _____ • _____ • _____ • _____

Unless a student meets one of the 14 stated Exceptions, the student is INELIGIBLE for participation in any of the sports listed above (item #15) during the 2025-2026 school year. Students are eligible for participation in sports NOT listed above (item #15).

Today's Date _____ **IN THE PAST 12 MONTHS?**

17. YES NO While at the **previous high school, the student was coached by** any member of our high school's coaching staff (current or incoming). If yes, indicate the name of the coach(es) and sport(s):

_____

RECOMMENDED VERIFICATION & COMMUNICATION BETWEEN SCHOOLS

By my signature below, I state that the above is true and accurate. I also understand that contests the student participates in may be forfeited to opponents if the information submitted is not accurate:

_____ _____ _____ _____
STUDENT DATE PARENT/GUARDIAN DATE

_____ _____ _____
NEW SCHOOL ATHLETIC DIRECTOR DATE SCHOOL NAME + EMAIL OR FAX

TO PREVIOUS SCHOOL A.D. - PLEASE SIGN AND RETURN TO A.D. AT THE STUDENT'S NEW SCHOOL

Exchange this form between athletic directors for students who wish to play the same sport as played previously. The previous school athletic director indicates that to the best of their knowledge, the above is true and accurate:

_____ _____ Form Returned to NEW School: _____
PREVIOUS SCHOOL ATHLETIC DIRECTOR DATE DATE

Notes if previous AD declines to sign: _____

_____

_____

_____

_____

ALERT! The Sport Specific Transfer Rule states: ANY sport a student played in 2024-25 determines eligibility in 2025-26 should the student transfer and not meet one of the 14 stated Exceptions.

OVER →

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 one 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:*_____

Primary 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:

One 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:_____

Office Use: ☐ New enroll ☐ Sibling add

Primary Bus Assigned_____ Alternate Bus Assigned_____

Thunder Bay
COMMUNITY HEALTH SERVICE, INC

School Based Health Center
Consent for Treatment, Privacy Acknowledgement, Payment Agreement & Questionnaire

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

Address: _____ City: _____ State:_____ Zip:_____

Grade: _____ School: _____ Male_____ Female _____

Legal Guardian Name: _____ Relationship to Patient: _____

Guardian Date of Birth: ____/____/____ Phone Number: _____

Legal Guardian Name: _____ Relationship to Patient: _____

Guardian Date of Birth: ____/____/____ Phone Number: _____

Name of Patient's Insurance: _____ Beneficiary ID#: _____

Insurance Address: _____ Insurance Phone Number: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Subscriber's Social Security Number: _____

Total Annual Family Income. (Please circle appropriate box)

1 member	0-$15,650	15,651-20,867	20,868-26,083	26,084-31,300	$31,301 +
2 members	0-$21,150	21,151-28,200	28,201-35,250	35,251-42,300	$42,301 +
3 members	0-$26,650	26,651-35,533	35,534-44,417	44,418-53,300	$53,301 +
4 members	0-$32,150	32,151-42,867	42,868-53,583	53,584-64,300	$64,301 +
5 members	0-$37,650	37,651-50,200	50,201-62,750	62,751-75,300	$75,301 +
6 members	0-$43,150	43,151-57,533	57,534-71,917	71,918-86,300	$86,301 +

Ethnicity (Please circle)

Are you Hispanic or Latino? ☐ Yes ☐ No

Race (Please circle)

Asian
Native Hawaiian
Other Pacific Islander
Black African American
American Indian/Alaska Native
White
More than one race

Are you homeless? ☐ Yes ☐ No

If yes, please circle:

Shelter
Street
Transitional Housing
Doubled Up
Other (hotels, day to day housing)
Unknown (homeless/none of the above)

1. We provide enrollment assistance to uninsured and underinsured to obtain health insurance. Would you like us to contact you about this? _____Yes _____No

2. Is English your primary language? _____Yes _____No

   If no, what language are you best served in? _____

Delegation of Consent for Treatment of Your Child: You may appoint individuals over the age of 18 of age to authorize treatment in your absence. I, being the parent or legal guardian of the above-named minor, do hereby appoint the following individual(s) to act on my behalf in authorizing medical, surgical, care, and hospitalization for my minor child. In no event shall this delegation of parental rights be effective for more than 12 months.

Contact Name: _____ Contact Name: _____

Relationship: _____ Relationship: _____

Phone Number: _____ Phone Number: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

OVER------>

Thunder Bay
COMMUNITY HEALTH SERVICE, INC.

Name of Primary Care Provider: _____ Telephone: _____

Name of Student's Pharmacy: _____ Date of Last Well Child Exam: _____

Medical and Mental Health History

Medications	Dose	Frequency	Dose

Allergies	Reaction Severity

Self and Family History: List any chronic health conditions and student surgical history below

By signing this form, I acknowledge the following:

Consent for Treatment: I consent to routine diagnostic procedures, including but not limited to x-rays, blood draw, laboratory tests, and administration of medication and to medical treatment rendered by physicians and staff of Thunder Bay Community Health Service, Inc. and other health care providers who may be called upon to consult or assist in my care as judged necessary by my treating provider. I understand that by law, the Michigan Public Health Code, if a Thunder Bay Community Health Service employee or associate receives an open wound, percutaneous, or mucous membrane exposure to my blood or other body fluids, my blood may be drawn and HIV (AIDS) testing may be performed on me without my prior written consent. **I understand that no contraceptives may be prescribed or dispensed on school property. I understand that abortion counseling, referrals, or services cannot be provided at the school-based health center.**

Sharing Health Information: Under the Health Insurance Portability and Accountability Act (HIPAA), a health care provider or agency may use and share most of your health information to provide you with treatment, receive payment for your care, and manage/coordinate your care. However, your consent is required to share certain types of health information with other people you may wish to have involved in your health care.

Behavioral Health Services: I acknowledge that behavioral health services are available upon request. These services include but are not limited to, individual counseling, family counseling, substance abuse counseling & referral, physical and sexual abuse counseling & referral. I understand that all healthcare information is confidential. Confidentiality between the student, parent/guardian and the therapist is assured. By law, some information requires the student's signed consent prior to disclosure to anyone, including parents/guardians. The SBHC staff will encourage every student to involve his/her parent/guardian in health care decisions.

Authorization for Payment Agreement: We participate with many insurance carriers including Medicare and Medicaid. As a courtesy to you, we will bill your insurance carrier directly for our services. You may be responsible for fees we do not collect. I authorize any insurance benefits to be paid directly to Thunder Bay Community Health Service, Inc. realizing I am responsible to pay non-covered services.

Privacy Practices Notice: I acknowledge being offered a copy of the Thunder Bay Community Health Service, Inc. Notice of Privacy Practices which is available at www.tbchs.org or by request.

Guardian Printed Name: _____

Guardian Signature: _____ **Date:** _____

REV 7/2022, 8/2022, 3/2023, 3/2025

Rogers City Area School District

Consent for Disclosure of immunization Information to Local and State Health Departments

Immunizations are an important part of keeping our children heathy. 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 students 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 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 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: ___/___/___

If you have any questions, please call Gabe Catalano at 989.734.9159

Please return to the school office for the school nurse.

Rogers City Area Schools
Application for Schools of Choice
School Year 2025-2026

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