

## **ACADEMY OF FLINT STUDENT REGISTRATION FORM**

**SCHOOL YEAR: 2012-2013** 

OFFICE USE ONLY			
Revised 2/28/2012			
Student ID Number			
Household Survey			
Certified Birth Record			
Immunizations			
Social Security Card			
Verified/Enrolled by:			

	STUDENT IN	FORMATION		
GRADE LEVEL for 2012-2013:	Will student attend Academy of Flint (Please Check Appropriate Answer) YESNO		Is this student currently eligible for Education Services? YES NO	•
Student's Last Name	First	M.I.	Social Security Number	Sex M F
Street Address		City	Zip	
Home Telephone Number	Parent/Guardian Name and Cell Phone N	umber	Emergency Contact Name and Phone Nu	ımber
Students Cell Phone Number	Parent/Guardian Name and Cell Phone Number  Student's Date of Birth			
Concerns About Your Child:	Incarcerated Parent? Yes ( ) No ( )	Homeless? Yes ( ) No ( )	Foster Care? Yes ( ) No ( )	
It is imperative that the above in	formation is completed in order to re	serve a seat for your stude	nt in the upcoming school year.	

Concerns About Your Child:	Incarcerated Parent? Ye	'es ( ) No ( )	Homeless? Yes ( ) No ( )	Foster Care? Yes ( ) No	( )
It is imperative that the above inf	formation is completed	d in order to res	erve a seat for your stude	nt in the upcoming school	year.
	-		•		•
Parent/Guardian Signature					Date

#### **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 II. 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.)

PER	S	ONAL												
CHILD	)'S	NAME (Last, First, Middle)					_				DATE OF BIRTH (mm/dd	/уу)		_
					/	/								
ADDRESS (Number & Street) (City) (ZIP Code)			le)	TODAY'S DATE (mm/dd/	уу)		_							
MI / /														
PAREN	NΤ	/GUARDIAN (Last, First, Midd	le)								HOME TELEPHONE NUI	MBE	R	_
											( )			
ADDRI	ES	S (Number & Street)	(Gity)						(ZIP Cod	le)	WORK TELEPHONE NU	MBE	R	_
									MI		( )			
			SECTI	ON	11-	HE	AL	TH	HISTORY					_
								T						_
Yes	4	# Is your child h	aving any of the problems listed	l be	elov	w?			Birth History:					
	_		actions (for example, food, medica			_	her)							_
		2 Hay Fever, Asth						٦						_
			quent Skin Rashes					٦						_
		☐ 4 Convulsions/Se	·					7						_
		☐ 5 Heart Trouble						7				_		_
		☐ 6 Diabetes						7			-			_
		7 Frequent Colds	s, Sore Throats, Earaches (4 or mo	ore	per	yea	ar)	٦	Are there any current	or past diagr	nosis(es)	J N	0	_
		☐ 8 Trouble with Pa	assing Urine or Bowel Movements	,				٦	If yes, please describe	9:				
		☐ 9 Shortness of B	reath					٦						
		☐ 10 Speech Proble	ms					7						
		☐ 11 Menstrual Prob	lems					٦			-			
		☐ 12 Dental Problem	s: Date of Last Exam /		/			7						
		☐ Other (please desc	cribe):					7						
☐ ☐ Does your child take any medication(s) regularly?				3	If yes, list medications	s:								
Re	a	son for Medication							>					
								$\perp$						
/ /					Was the health history	reviewed by	y a health professions	11?						
		Parent/Guardian	Signature Da	ate					☐ Yes ☐ No	Examine	r's Initials:	_		_
		SECT	ION II - PHYSICAL EXAMINA	\TI	ON	, IN	ISF	EC	TION, TESTS AND M	EASUREM	ENTS			_
			Required for Child (	Car	e a	ind	He	ad S	Start / Early Head Star	t				
			Tes	ts a	anc	i M	eas	sure	ements					
	T					3re	Γ							g
				lag	Referred	Under Care		}				Tall	eferred	nder Care
S &	3	Was child tested for:	Test results:	₽	墨	트	2	Yes	Was child tested for:	Test results:		호	Referred	2
		VISION	Visual Acuity						HEIGHT & WEIGHT	Height				
ے اد	1		Muscle Imbalance							Weight	•			
		Date: / /	Other:						Other:	Other				
T	T	HEARING	Audiometer						HEMOGLOBIN / HEMATOCRIT		⇒			Γ
	1		Other:						BLOOD PRESSURE	Pandine				
		Date: / /					Lu		DECOR FRESSURE	neauing:				
	T	URINALYSIS	Sugar				Г		TUBERCULIN	Type:				
l.c			Albumin											
	- 1	Date: / /	Microscopic				Ĺ		Date: / /	Neg.: □ Pos	.: 🗆 mm			
	T	BLOOD LEAD LEVEL							Blood lead level required fo					
-1 c	,		Level ug/dl			$\Rightarrow$			and two years of age, or outlined and two years of age, or outlined and and and and are and and are and and are are and are are and are					
	- 1	Date: / /							same intervals as listed abov				.50	
	42			nina	tior	ns ai	nd/c	or Ins	spections					_
:ssen	1tia	I Findings Deviating from Nor	mai:				_							_
														_
										Fyar	n 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		VACCINES (Circle Type)	DATE ADMINISTERED  MM/DD/YYYY			
Hepatitis B	1	3	Hepatitis A (Hep A)	1	2		
(Hep B)	2			1	3		
	1	4	Influenza TIV/LAIV	2	4		
DTaP/DTP/DT/Td	2	5	Meningococcal MCV4 / MPSV4	1	2		
	3	6	Human Papillomavirus	1	2		
Tdap	1		(HVP4/HPV2)	2	3		
Haemophilus Influenzae	1	3	(	Type of Vaccine(s)	Date of Vaccine(s)		
type b (HIB)	2	4	OTHER Vaccines	1			
Polio - IPV / OPV	1	3	Specify Date & Type	2			
F010 - 1FV / OFV			Specify Date a Type	3	-		
	2	4		1 -			
Pneumococcal Conjugate	1	3	Indicate and attach physician diagnosis of	or laboratory evidence of	immunity as applicable		
(PCV7/PCV13)	2	4	*NOTE: According to Public Act 368 of 1				
Rotavirus (RV1/RV5)	1	3	the first time must be adequately Exemptions to these requiremen				
	2		objections, provided that the wa	iver forms are properly pr	repared, signed and		
Measles,Mumps, Rubella (MMR)	1	2	delivered to school administrator your child's school or local healt		ptions are available at		
Varicella (Chickenpox)	1	2	your child's school of local fleah	п оераниен.			
History of Cickenpox Disease?   Yes	☐ No If yes, date:		Parent/Guardian refused immunizations:				
I certify that the immunization dates are tri	ue to the best of my knowle	edge					
					/ /		
Health Professional's Signature Title Date			Date				
SECTION IV - RECOMMENDATIONS 은 일 (Required for Child Care and Head Start/Early Head Start)							
□ 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							
		DUMOICIAN	COLONATURE				
PHYSICIAN'S SIGNATURE							
					-		
Examiner's Signatu	ire	Date	Examiner's Name (Prin	t or Type)	Degree or License		
		_	MI	(	)		
Number & Stree	et		City ZI	P 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 schedule of well-child care 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 and regular intervals based on age.

Developed in Cooperation with the Departments of Human Services, Education, Community Health, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.

# **Academy of Flint**

### **Food Substitution Form**

Student's Name:	Homeroom:
	ecify) d Dye Allergy Iron Intolerance ther (Please Specify)
Milk Only Nuts (Please Specify) Other (Please Specify):	Fruit (Please Specify) Wheat Product None
Food(s) To Be Substituted In Place of Food(s) To Rice Milk Products Soy Milk Products	
Please complete the following if your child is ph Description of condition and indication th	· · · ·
Description of major life activity affected	by condition:
Signature of Parent/Guardian:	Date

# Academy of Flint PHOTO/VIDEO RELEASE FORM

I hereby give my permission for the Academy of Flint to photograph and video my child and use such photographs and/or videos in which my child appears anonymously in promotional materials for the Academy of Flint. I acknowledge, understand and agree that neither myself or my child will receive any type of financial compensation and that by signing this document we are releasing the Academy of Flint from any future claims as well as from any liability arising from the use of such photographs and/or videos.

Student's Name:	
Parent's Name:	
Parent's Signature:	Date: