



To enroll your child(ren) in the Adrian Public Schools, the following information must be provided.

✓ **BIRTH CERTIFICATE**

A person enrolling a student for the first time must provide the school with a **certified** copy of the student's birth certificate (PA 84 of 1987). Failure to comply with this request, or if the documents are inaccurate and/or suspicious in nature, will result in the school sending parent/guardian notification of the need to comply within 30 days or the matter will be referred to the local law enforcement agency.

✓ **IMMUNIZATION RECORD**

State law requires all new school entrants to be immunized against Hepatitis B, Measles, Mumps, Rubella, Polio, Varicella (Chickenpox) and DTaP/DTP/DT. Upon entering the 6th grade or higher students must have the Meningococcal vaccination (PA 386, Section 92 of 1978 as amended). Parents/guardians must provide the school with a record showing that their child has received all of these required immunizations or a wavier must be signed. Children who have not completed the required immunizations will be excluded from school until such requirements are met.

The Lenawee County Health Department is located in the Human Services Building located at 1040 S. Winter Street, Adrian, MI. You may contact them at 264-5226 regarding immunizations.

✓ **PROOF OF RESIDENCY**

Students must attend the school district in which their parent or legal guardian maintains their legal residence. Change of guardianship is not permitted for the purpose of attending a specific school/school district.

Proof of legal residence is required by the school district of a parent/guardian when enrolling a student for the first time. Acceptable forms of proof of residency include:

- 📄 Copy of a property tax statement
 - 📄 Mortgage documents that prove ownership
 - 📄 Copy of a lease agreement
 - 📄 Copy of a utility bill
- A DRIVER'S LICENSE IS NOT ACCEPTABLE

✓ **REGISTRATION FORM**

✓ **HOME LANGUAGE SURVEY**

✓ **RACE/ETHNICITY FORM**

✓ **TRANSPORTATION INFORMATION SHEET** (if applicable)

✓ **CONCUSSION AWARENESS FORM**

✓ **IEP IF STUDENT HAS ONE**

✓ **RECORDS REQUEST FROM PRIOR SCHOOL** (if applicable)

✓ **ANY LEGAL DOCUMENTATION NECESSARY** (custody, etc)



Adrian Public Schools Registration Form

2020-2021

Legal Last Name	Legal First Name	Legal Middle Name	Birthdate	Grade	Legal Gender	Birth City	Birth State

Street Address	City-State-Zip	Student Cell Phone	Student Email	Last School Attended	Medical Conditions/Allergies

Check all that apply: American Indian Asian Black White Native Hawaiian Multi-Racial, specify _____ Hispanic/Latino Ethnicity: No Yes

Primary Language Spoken at Home: English Spanish French German Other, specify _____ Is student currently receiving Special Education Services? No Yes Specify: _____

Parents/Guardians Contact Information: Note: Priority is the order in which the parent/guardian is to be contacted.

Priority	Parent/Guardian Name	Lives With	Relationship	Address	Phone	Email	Employer & Employer Phone
		Y / N					
		Y / N					
		Y / N					
		Y / N					

Automated alert messages will be sent to the numbers listed below. I acknowledge that I am authorized to make decisions regarding automated calls and text messaging made to the phone numbers provided on this form. Please fill out for only those wishing to be contacted. If you would also like a text message sent, check the box next to the alert number. Alerts 3-6 are for Emergency Alerts such as closings & delays.

Primary Alert 1 (Attendance/All Alerts): _____ Alert 3: _____ Alert 5: _____
 Primary Alert 2 (All Alerts): _____ Alert 4: _____ Alert 6: _____

Please notify the building immediately if any of these numbers change at any point throughout the school year.

Emergency contacts:			Please list below the names of other children presently living in your home:			
1. Name:	Relationship:	Phone:	Name of Additional Child:	Birthdate:	Current Grade:	Relationship:
2. Name:	Relationship:	Phone:	Name of Additional Child:	Birthdate:	Current Grade:	Relationship:
3. Name:	Relationship:	Phone:	Name of Additional Child:	Birthdate:	Current Grade:	Relationship:

Extra copy of report card should be sent to non-custodial parent? No Yes, Parent Name & Address: _____

Resident of this School District School of Choice (Non-Resident) Non-Resident Attending

Is there any legal information or documents that the school should be informed of concerning the above student? No Yes If Yes, please attach _____

SEE REVERSE SIDE FOR SIGNATURE SECTION & ADDITIONAL REQUIRED INFORMATION OVER ----->

FOR OFFICE USE ONLY:

Start Date:	Student Id:	Homeroom #:	Homeroom Teacher:	Locker:	Counselor:	Bus To:	Bus From:

Yes No

TECHNOLOGY USE POLICY

As the student’s parents or legal guardians, we agree to read and uphold the school technology use policy and discuss it with our son or daughter. We understand that internet access is a privilege provided for educational purposes. We understand that it is impossible for the district and all LISD programs to restrict access to all controversial material. The district, including all LISD programs, its employees and agents and individual members of the Boards of Education are released from any and all claims or causes of action arising out of our son’s or daughter’s use or misuse of the Network or Network equipment. In addition, the district and all LISD programs are indemnified of any fees, expenses or damages incurred as a result of our son’s or daughter’s use or misuse of the Network or Network equipment.

Yes No

As the student’s parent/legal guardian, I give my student permission to enroll in online learning.

Yes No

As a student taking an online course, I agree to meet with my teacher mentor weekly and go over my progress. I also agree to complete my course(s) by the end of the marking period to receive a grade and credit.

EMERGENCY MEDICAL AUTHORIZATION

In case of accident involving injury, or suspected injury, or in the case of illness involving my child named on this form, district staff and all LISD program staff will transport or secure an ambulance to transport said child to the nearest available emergency room when on school property or away on school-related activities. School personnel will authorize an emergency room doctor to treat my child and call another doctor for consultation and treatment in the event special treatment is necessary, such as surgery, orthopedics, etc. School personnel will hold this authorization as long as named student is enrolled in this school district.

USE OF STUDENT INFORMATION

Throughout the year, students are awarded honors for academics, activities, and other miscellaneous items. In such an event, the district, including all LISD programs, will authorize local businesses to publicize these accomplishments through electronic or printed media. District and all LISD program personnel will authorize use of only pertinent information without jeopardizing the security of your child.

PHOTOGRAPHING/VIDEO TAPING

During the course of the year, photographs and/or video may be taken for use in public relations and school-related publications. School personnel, including all LISD programs, are authorized to supervise possible photographing or videotaping of my child related to classes and school activities on school grounds or events. Reproductions of videotaping or photographs may be used electronically and in print by the administration for the purpose of school publicity.

POLICIES

Policies guide district staff in providing a safe and orderly atmosphere in which all students can learn. Copies of complete policies are available at your school, online at www.theadrianmaples.com or from the Administrative Offices. Any time you have a question or concern, please request a copy of a policy. **The following policies are reviewed at the beginning of each school year with students, but we ask that parents review them as well with their child(ren).**

- Attendance Policy – District
- Bullying Policy
- Technology Policy
- Harassment Policy
- Administering of Medications Policy
- Department of Education Eye Protection Device Information
- Religion Policy
- Weapons Policy
- Student Code of Conduct
- Code of Student Conduct Bus Rules
- AHS Student Handbook (On the Web Only)

PARENT/GUARDIAN AND STUDENT ACKNOWLEDGEMENT

We, the undersigned, agree to read, uphold and discuss the above information/policies with our child. We understand the rights and responsibilities pertaining to students and agree to support and abide by the rules, guidelines, procedures, and policies of the School District and all LISD programs. We acknowledge that we are authorized to make decisions regarding automated calls and text messaging made to the phone numbers provided on this form.

Parent or Legal Guardian Signature

Date

Student Signature

Date

This form must be signed and returned in order for the student to register.

Parent/Student- Please read and sign on the reverse side. Every student must have a Concussion Awareness form on file with Adrian Public Schools. This form will be kept with the student's permanent records until the student graduates or transfers from the district.

ADRIAN PUBLIC SCHOOL PARENT & STUDENT CONCUSSION INFORMATION SHEET

WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If a student reports one or more symptoms of concussion after a bump, blow, or jolt to the head or body, she/he should be kept out of play the day of the injury. The athlete should only return to play with permission from a health care professional experienced in evaluating for concussion.

DID YOU KNOW?

- Most concussions occur without loss of consciousness.
- Students who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

SYMPTOMS REPORTED BY STUDENT;

- Headache or "pressure" in the head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

SIGNS OBSERVED BY STAFF:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events after hit or fall



OVER →→→

CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. A student should receive immediate medical attention if after a bump, blow, or jolt to the head or body she/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously)

WHAT SHOULD YOU DO IF YOU THINK YOUR CHILD HAS A CONCUSSION?

1. If you suspect that a student has a concussion, remove the student/athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the student out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says he/she is symptom-free and it's okay to return to play.
2. Rest is key to helping a student recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, and playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.
3. Remember: Concussions affect people differently. While most students with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

WHY SHOULD A STUDENT REPORT THEIR SYMPTOMS?

If a student has a concussion, his/her brain needs time to heal. While a student's brain is still healing, he/she is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young children can result in brain swelling or permanent damage to their brain. They can even be fatal.

STUDENT NAME PRINTED

STUDENT NAME SIGNED

DATE

PARENT OR GUARDIAN NAME PRINTED

PARENT OR GUARDIAN NAME SIGNED

DATE



Dear Parent/Guardian:

All school districts in Michigan are required to report student data by race and ethnicity categories set by the U.S. Department of Education. Race and ethnicity data is collected utilizing a two-part question format. This allows individuals to more accurately identify themselves given the increased diversity of our nation.

These reports help keep track of changes in student enrollment and ensure that all students receive the educational programs and services to which they are entitled.

If we do not receive a response from you, an employee of the school district will be required to provide this information based on observations. Federal regulations do not permit school districts to leave the questions blank.

Student's name: _____ Grade: _____

PLEASE ANSWER BOTH: PART A about Hispanic origin AND PART B about race

Part A is about ethnicity, not race. Regardless of what you selected in Part A, **answer Part B** by marking one or more boxes to indicate what you consider your student's (or your) race to be.

PART A Is this student Hispanic/Latino? (Choose only one)

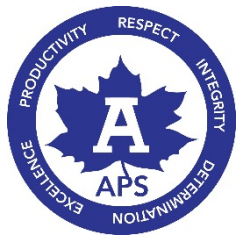
- No, not Hispanic/Latino
- Yes, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race.)

PART B What is the student's race? (Choose one or more)

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

NOTE: **Both parts A and B must be completed.** We encourage you to select an answer for **both** parts. 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.

Parent/Guardian Signature: _____ Date: _____



Transportation Request Form

School _____

Date: _____

Circle One: New Request Change request

Student Name: _____ Grade _____

Student Name: _____ Grade _____

Student Name: _____ Grade _____

Student Name: _____ Grade _____

Home Address: _____

_____ Phone Number _____ Emergency # _____

Primary Pick Up Address: _____ APT.# _____

City: _____

Primary Drop Off Address: _____ APT.# _____

City: _____

Circle One: AM PM Both

Circle One: Daily Weekly

Alt. Pick Up Address: _____ APT.# _____

City: _____

Alt. Drop Off Address: _____ APT.# _____

City: _____

Circle One: AM PM Both

Circle One: Daily Weekly

_____ Phone Number

_____ Emergency #

Print Parent/Guardian Name

Parent Guardian Signature

Required Childhood Immunizations for Michigan School Settings

Healthcare providers in Michigan should follow the 2012 Recommended Immunization Schedule

For more information, see www.michigan.gov/immunize

Entry Requirements for All Public & Non-Public Schools		
Age → Vaccine** ↓	4 years through 6 years	7 years through 18 years including all 6th grade students
Diphtheria, Tetanus, Pertussis	4 doses DTP or DTaP, one dose must be on or after 4 years of age	4 doses D and T OR 3 doses Td if #1 given on or after 7 years of age. 1 dose of Tdap*** for children 11 through 18 years IF 5 years since the last dose of tetanus/diphtheria containing vaccine.
Polio	4 doses, if dose 3 administered on or after 4 years of age, only 3 doses are required	3 doses
Measles,* Mumps,* Rubella*	2 doses on or after 12 months of age	
Hepatitis B*	3 doses	
Meningococcal****	None	1 dose for children 11 years of age or older upon entry into 6 th grade or higher
Varicella* (Chickenpox)	2 doses of varicella vaccine at or after 12 months of age OR current lab immunity OR reliable history of disease	

* Current laboratory evidence of immunity is acceptable instead of immunization with antigen.

** All doses of vaccines must be given with appropriate spacing between doses and at appropriate ages to be considered valid.

***Tdap is required at 11 years of age or older regardless of grade.

****Meningococcal is not assessed in MCIR/SIRS if the child is 11 years of age and in a grade lower than 6th grade.



**LENAWEE COUNTY
HEALTH DEPARTMENT**

1040 S. Winter Street, Suite 2328
Adrian, MI 49221

Phone | 517-264-5226
Fax | 517-264-0790
LenaweeHealthDepartment.org



TO PARENTS OF CHILDREN 3 THROUGH 5 YEARS OF AGE:

Dear Parent:

Michigan law requires that children entering kindergarten have a vision and hearing screening prior to school entrance.

The Lenawee County Health Department and the Michigan Department of Public Health sponsor a hearing and vision program for preschool children. They are interested in testing the hearing and vision of all children 3 through 5 years of age, especially all who will enter kindergarten in the fall. This service is being provided without cost to the parents. A report and recommendation concerning each child will be given to parents following the testing.

A surprising number of children have vision or hearing difficulties that are not even suspected. Many are found through the vision or hearing screening test and referred to a doctor. Defects are much easier to correct at an early age and some permanent handicaps can be prevented.

If you would like to enroll your child or children within this age group in the program, please call us at **517-264-5254** to schedule an appointment.

HEARING AND VISION SCREENING PROGRAM

The mission of the Lenawee County Health Department is to promote a safe and healthy environment.

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 Adrian Public Schools 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: _____

ADRIAN PUBLIC SCHOOLS KINDERGARTEN QUESTIONNAIRE

The following questions are not intended to be an invasion of privacy, but to assist teachers in preparing for and working with your child. The following information will be kept confidential. Thank you for helping us to get to know more about your child before we have the pleasure of working with him/her.

Child's Name: _____ Date of Birth: _____

1. What does your child want to be called at school? Does he/she have a nickname?

2. Has your child attended nursery school, pre-school, and/or Head Start?

How long did your child attend? _____

Is this your child's first school experience? Yes No

3. Does your child have any health problems? If so, please explain.

4. Has your child ever had chicken pox? Yes No

5. Was the pregnancy full term or premature?

6. Please describe in some detail your child's personality and behaviors. You may want to use words like aggressive, active, shy, quiet, likes to talk.

7. Does your child have any fears? If so, please explain.

8. How does your child react when you leave him/her with another adult? Is separation particularly difficult or easy for him/her? Please explain.
9. How many children are in the family? _____ In your home? _____
Is your child the oldest, youngest, or middle?
10. Does your child nap during the day? Yes No
11. What types of things work with your child when you need to adjust his/her behavior? How do you discipline your child at home?
12. What is our child's normal bedtime? _____ How many hours does your child sleep? _____
Does your child sleep through the night? Yes No
13. What TV programs does your child watch?
14. How much TV does your child watch per week? _____
15. How much time are you able to read to your child per week? _____
16. What type of books does your child like?
17. What school readiness activities does your child choose to do at home?
18. What additional information might be helpful to the teacher while working with your child?

INSTRUCTIONS FOR COMPLETING THE HOUSEHOLD INFORMATION REPORT

A HOUSEHOLD MEMBER IS ANY CHILD OR ADULT LIVING WITH YOU.

IF ANY MEMBER OF YOUR HOUSEHOLD RECEIVES BENEFITS FROM THE FOOD ASSISTANCE PROGRAM (FAP), FAMILY INDEPENDENCE PROGRAM (FIP), OR FDPIR PLEASE FOLLOW THESE INSTRUCTIONS:

Part A: Enter the total number of individuals living in your household, including all children in the box provided.

Part B: List the case number for any household member (including adults) receiving FAP, FIP, or FDPIR benefits

Part C: List the First and Last name, Birth Date, School that the child is attending, and H if homeless, M if Migrant, R if Runaway or F if a Foster Child.

Part D: Skip this part

Part E: Sign the form. Print your name and Date.

IF YOUR HOUSEHOLD DOES NOT RECEIVE BENEFITS FROM THE FOOD ASSISTANCE PROGRAM (FAP), FAMILY INDEPENDENCE PROGRAM (FIP), OR FDPIR PLEASE FOLLOW THESE INSTRUCTIONS:

Part A: List the total number of individuals living in your household, including all children.

Part B: Skip this part.

Part C: List the First and Last name, Birth Date, School that the child is attending, and H if homeless, M if Migrant, R if Runaway or F if a Foster Child.

Part D: Enter all gross income for each type of income that applies. If you have no income for any 1 or more of the categories, Circle NONE if no income. Add lines 1-6 and enter the Total Monthly Household Income.

Part E: Sign the form. Print your name and Date.

School District Name
 ONLY
 Address
 for:
 Address
 Phone
 Email

Household Information Report

SCHOOL USE

Approved
 1 2

To determine eligibility for various additional state and federal program benefits that your school may qualify for, please complete, sign and return this report to _____.
(School Name)

These sections must be completed by the head of household or designee.

PART A. SIZE OF FAMILY - Enter the total number of individuals living in your household, including all adults and children → _____

PART B. CURRENT BENEFITS - Complete below if applicable

If any member of your household receives Food Assistance Program (FAP), Family Independence Program (FIP), or FDPIR, provide the name and case number for the person who receives benefits. Bridge Card Numbers and Medicaid Numbers are NOT ACCEPTABLE case numbers.

Name: _____ Case Number: _____

PART C. STUDENT INFORMATION – Complete for each student Pre-K through 12th Grade

Last Name	First Name	Birth Date XX-XX-XXXX	School	Identify H if Homeless M if Migrant R if Runaway F if Foster

If you need additional lines, attach a second sheet to this report or attach a copy of this report clearly marked as a **Page 2**.

PART D. TOTAL MONTHLY HOUSEHOLD INCOME – Report income for all members of household excluding Foster Children. If you have reported a case number above, you do not need to fill in this section. Simply sign and date form.

Type of Income	Income	Circle if None
1. Gross Monthly Earnings: Wages, Salary, Commissions	\$	None
2. Monthly Welfare Payments, Child Support, Alimony	\$	None
3. Monthly Payments from Pensions, Retirement, Social Security	\$	None
4. Monthly Dividends or Interest on Savings	\$	None
5. Monthly Worker's Compensation, Unemployment, Strike Benefits	\$	None
6. Other Monthly Income (SSI, VA, Disability, Farm, other)	\$	None
Total Monthly Household Income (Add lines 1-6)	\$	

PART E. SIGNATURE - I certify (promise) that all information on this report is true and that all income is reported. I understand that the school will get federal/state funds based on the information I give. I understand that school officials may verify (check) the information.

 (Signature) (Printed Name) (Date)

 (Address) (City) (Zip)

 (Home Phone) (Work Phone) (Email Address)



Families in Transition Form

Check ONLY those that apply:

- Living in a shelter (code 10)
- Living with friends or relatives temporarily (code 13)
- Living in a hotel or motel (code 14)
- Unsheltered (code 15)
- Transitional Program through Housing Help (code 11)

Are you living without your parent/guardian? Y N
 Placed in Foster Care? Y N

Date: _____



If none of the above apply, please disregard this form



This form is to be completed by the responsible party for the student(s) listed below. Please list your contact information including your name, address and phone number(s):

Name(s) of Responsible Party

Address

1. _____
2. _____

Phone Number(s): Cell: _____ Home: _____ Work: _____

Relationship to Student(s):

- Parent(s) Legal Guardian Person(s) acting as a parent in the absence of a parent or guardian
- Student (not living with parent/guardian)

Name of Student(s)

Building

Grade

1. _____
2. _____
3. _____
4. _____

Students and families who qualify as a Family In Transition may receive additional services such as:

- ◆ Immediate enrollment while receiving assistance retrieving birth certificates
- ◆ Immediate enrollment without a permanent address
- ◆ Students may continue to attend the same school they attended prior to the temporary move
- ◆ Transportation assistance is provided to and from school
- ◆ School supplies, clothing assistance and personal care items

For more information please contact: Families in Transition Coordinator Angela Pooley at (517) 266-4529

FOR OFFICE USE ONLY:

Start Date Entered In eSchool: _____

Date Sent to FIT Coordinator: _____

Notification Sent to Other Building(s):

Free Lunch Marked in eSchool:

Completed By: _____

FIT COORDINATOR USE ONLY:

Verified FIT Status

Unapproved

Signature: _____

Date: _____

Form Returned to Building(s):