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

<table>
<thead>
<tr>
<th>Legal Last Name</th>
<th>Legal First Name</th>
<th>Legal Middle Name</th>
<th>Birthdate</th>
<th>Grade</th>
<th>Legal Gender</th>
<th>Birth City</th>
<th>Birth State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City-State-Zip</th>
<th>Student Cell Phone</th>
<th>Student Email</th>
<th>Last School Attended</th>
<th>Medical Conditions/Allergies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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

## Parents/Guardians Contact Information

<table>
<thead>
<tr>
<th>Priority</th>
<th>Parent/Guardian Name</th>
<th>Lives With</th>
<th>Relationship</th>
<th>Address</th>
<th>Phone</th>
<th>Email</th>
<th>Employer &amp; Employer Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Note: Priority is the order in which the parent/guardian is to be contacted.

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

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***

**FOR OFFICE USE ONLY**

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

OVER --->
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.

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 TASING

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.

Revised 2/2020
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, s/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 this student Hispanic/Latino? (Choose only one)
- [ ] No, not Hispanic/Latino
- [x] 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: __________

Revised 8/9/13
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_____________________________________

Please return to your child’s school. First Student, District Transportation Provider, can be reached at 517-263-2464. District Transportation Policy can be found at https://www.adrianmaples.org/parents/transportation.php
ADRIAN PUBLIC SCHOOLS 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 380.1151 – 380.1155 of the School Code of 1995, Michigan's Bilingual Education Law. Would you, please help by providing the following information? Thank you very much for your cooperation.

Name of Student: ____________________________
Last First Middle
Grade: ________ Birthdate: ____________

School Building: ____________________________

1. Is your child’s native tongue a language other than English?  No ________ Yes ________ What is that language? __________________________

2. Is the primary language used in your child’s home or environment a language other than English?  No ________ Yes ________ What is that language? __________________________

Parent or Guardian Signature: ____________________________ Date: ____________

Parent/Guardian Address: ____________________________

---

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

ENCUESTA SOBRE EL IDIOMA DEL HOGAR

ADRIAN PUBLIC SCHOOLS necesita una información acerca de los idiomas que los estudiantes hablan o entienden; y acerca del idioma con el cual el estudiante ha nacido y si lo usa en casa. Esta información será usada por el distrito escolar para determinar el número de estudiantes que pueden calificar para recibir una educación bilingüe de acuerdo a las Secciones 380.1151 – 380.1155 del Código Escolar de 1995, Ley sobre la Educación Bilingüe de Michigan. Por favor responda a las siguientes preguntas.

Nombre del estudiante: ____________________________
Apellido Nombre Segundo nombre
Grado: ________ Edad: ____________

Nombre de su escuela: ____________________________

1. ¿Es el idioma nativo de su hijo(a) otro aparte del inglés?  No ________ Si ________ ¿Cuál es ese idioma? __________________________

2. ¿Es el idioma principal usado en la casa o “barrio” de su hijo(a) un idioma diferente al inglés?  No ________ Si ________ ¿Cuál es ese idioma? __________________________

Firma del padre o guardián: ____________________________ Domicilio Fecha: ____________________________

Domicilio del padre o guardián: ____________________________

---

1 "Idioma nativo" significa “El idioma en que el/la niño(a) primero comenzó a entenderse con sus padres.”

2 "Idioma principal" significa “el idioma dominante usado por una persona para comunicarse.”
**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

<table>
<thead>
<tr>
<th>Age</th>
<th>Vaccine**</th>
<th>7 years through 18 years including all 6th grade students</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 years through 6 years</td>
<td>4 doses DTP or DTap, one dose must be on or after 4 years of age</td>
<td>4 doses D and T OR 3 doses Td if #1 given on or after 7 years of age.</td>
</tr>
<tr>
<td>7 years through 18 years</td>
<td>1 dose of Tdap*** for children 11 through 18 years IF 5 years since the last dose of tetanus/diphtheria containing vaccine.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vaccine**</th>
<th>4 doses, if dose 3 administered on or after 4 years of age, only 3 doses are required</th>
<th>3 doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polio</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vaccine**</th>
<th>2 doses on or after 12 months of age</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles,* Mumps,* Rubella*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vaccine**</th>
<th>3 doses</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vaccine**</th>
<th>None</th>
<th>1 dose for children 11 years of age or older upon entry into 6th grade or higher</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meningococcal****</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vaccine**</th>
<th>2 doses of varicella vaccine at or after 12 months of age OR current lab immunity OR reliable history of disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicella* (Chickenpox)</td>
<td></td>
</tr>
</tbody>
</table>

* 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.
### PERSONAL
- **Child's Name:**
- **Last Name:**
- **First Name:**
- **Middle Name:**
- **Sex:**
- **Date of Birth:**
- **Today's Date:**
- **Address:**
- **Number & Street:**
- **City:**
- **Zip:**
- **Telephone (Home):**
- **Telephone (Work):**

### SECTION I - HEALTH HISTORY

<table>
<thead>
<tr>
<th>1. Allergies or reactions: (for example, food, medication, or other)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Hay fever, asthma, or wheezing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Eczema or frequent skin rashes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Convulsions/seizures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Heart trouble</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Frequent colds, sore throats, earaches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Trouble with passing urine or bowel movements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Shortness of breath</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Speech problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Intellectual problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Dental problems: date of last examination:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please explain any problems areas identified above:

---

### SECTION II - IMMUNIZATIONS

### VACCINE

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>DATE ADMINISTERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>TYPE</td>
<td>DTP</td>
</tr>
<tr>
<td>DTaP/Pertussis (PSP)</td>
<td>Type</td>
</tr>
<tr>
<td>DT</td>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
<td>7.</td>
</tr>
<tr>
<td>3.</td>
<td>8.</td>
</tr>
<tr>
<td>4.</td>
<td>9.</td>
</tr>
<tr>
<td>5.</td>
<td>10.</td>
</tr>
<tr>
<td>Haemophilus Influenzae type b (Hib)</td>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>POLIO IPV</td>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
<td></td>
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<tr>
<td>3.</td>
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</tbody>
</table>

Note: Immunization data must be updated by the child's physician.

### RELIGIOUS OBJECTIONS

I certify that the immunization dates are true to the best of my knowledge.

---

**According to Act 309, Public Acts 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 waiver forms are properly prepared, signed, and delivered to school administration. Forms for these exemptions are available at your school or local health department.**
### SECTION III – PHYSICAL EXAMINATION, INSPECTION, TESTS, AND MEASUREMENTS

**EXAMINATIONS AND/OR INSPECTIONS**

**ESSENTIAL FINDINGS DEViating FROM NORMAL AND/OR RECOMMENDATIONS**

<table>
<thead>
<tr>
<th>TESTS AND MEASUREMENTS</th>
<th>Normal</th>
<th>Under Care</th>
<th>Referred</th>
<th>Normal</th>
<th>Under Care</th>
<th>Referred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Tested?</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes ☐ No ☐</td>
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</tr>
<tr>
<td>Date</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Visual Activity</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Yes ☐ No ☐</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ocular Muscle</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Yes ☐ No ☐</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
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<td>Urinalysis Done?</td>
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<td>Yes ☐ No ☐</td>
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<td>Hearing Tested?</td>
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<td>Yes ☐ No ☐</td>
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<td>Yes ☐ No ☐</td>
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<td>Hemoglobin/Hematocrit Tested?</td>
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<td>Yes ☐ No ☐</td>
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<td>Other:</td>
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<td>Blood Lead Level Tested?</td>
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<td>Yes ☐ No ☐</td>
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<tr>
<td>Blood Lead Level recommended for all children age six and under</td>
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</tbody>
</table>

**ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS**

<table>
<thead>
<tr>
<th>Tuberculin Test (if given)</th>
<th>Date</th>
<th>Type</th>
<th>☐ Negative</th>
<th>☐ Positive</th>
<th>mm</th>
</tr>
</thead>
</table>

### SECTION IV – RECOMMENDATIONS

Is there any defect of vision, hearing, or other condition for which the school could help by visiting or other action? ☐ Yes ☐ No
If Yes, please explain:

Should the student's activity be restricted because of any physical defect or illness? ☐ Yes ☐ No
If Yes, check below and explain degree of restriction:

☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Camp ☐ Other

Examiner's Signature
Date
Examiner's Name (print or type)
Degree or License
Number & Street
City
Zip
Telephone

### SECTION V – DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined

Child's Name

Thereafter, the following recommendations as for treatment:

Dentist's Signature
Date

COMMENTS
TO PARENTS OF CHILDREN 3 ½ 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 ½ 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.

Appointments will be scheduled during the four weeks in August at the First United Methodist Church, 1245 W. Maple Avenue.

If you would like to enroll your child or children within this age group in the program, please fill in this form and return it to your school or mail to the Lenawee County Health Department immediately. An appointment time will be sent to you at a later date throughout the summer months.

Parents Names:  
Father__________________________________
Mother__________________________________Phone #__________

Mailing Address: Street__________________________City______Zip Code____

School Attending In Fall ________________________________

Child’s or Children’s Name: ___________________________Age______

__________________________Age______

__________________________Age______

I wish to have the above named child or children participate in the Preschool Vision and Hearing Program.

Signature of Parent: _________________________________

PRESCHOOL HEARING AND VISION SCREENING PROGRAM

(517) 264-5202 Environmental Health, (517) 264-5204 Administration, (517) 264-5226 Clinics-Nursing, (517) 264-0790 FAX
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.
Household Information Report

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

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Birth Date</th>
<th>School</th>
<th>Identify</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>XX-XX-XXXX</td>
<td></td>
<td>H: Homeless</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M: Migrant</td>
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<td></td>
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<td>R: Runaway</td>
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<tr>
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<td>F: Foster</td>
</tr>
</tbody>
</table>

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.

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

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)

By providing your email address you may be contacted via email by the district.
**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

Are you 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):

<table>
<thead>
<tr>
<th>Name(s) of Responsible Party</th>
<th>Address</th>
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<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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</table>

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)

<table>
<thead>
<tr>
<th>Building</th>
<th>Grade</th>
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<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>3.</td>
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<td>4.</td>
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</table>

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): [ ]