School District of the City of Pontiac

Office of Student Services/ Tonya L. Dixson Director

WHAT TO BRING WHEN YOU ENROLL

The following information is provided to help guide families through the enrollment process. Please bring documentation with you when you come to enroll your child.

The Student Service Office is open weekdays from 8:00 am to 4: oo pm. Please call (248) 451-7527 with any questions.

Final enrollment is complete when all the following documents have been provided:

- Original Birth Certificate with seal (demonstration parentage of custodial parent) – **REQUIRED**
- Probate Court Guardianship or Foster Care Placement Papers (for legal guardians, demonstration relationship to child)
- Immunization Records – provided by a doctor or health department – **REQUIRED**
- Transcript **REQUIRED** for 10-12 grade student plus drop slip
- Last Report Card for grades 1st – 9th (if applicable transcript for 9th grade)
- Driver's License or State ID showing photo of parent/guardian name and current address
- Residence Documentation – Please bring one of the following:
  - Lease/Rental or Purchase agreement with name and address
  - Closing statement, warranty deed or occupancy permit indicating you have taken final possession
  - Property Tax Statement
  - Current Utility Bill
  - If residing in the home of another, please ask office staff for a **Residency Affidavit.**
- Vision Screening (Kindergarten Only) Oakland County Health Department offers FREE Screenings at 100 N Telegraph, Pontiac, MI 48341 248-424-7070
- Special Education Documents – Current **IEP/MET/504** for student receiving special services.

School District of the City of Pontiac

Enrollment Residency Questionnaire

Date of Enrollment: ________________ School Previously Attended: ___________________________

Student's Name: ______________________________________ Birthdate: ___________ Grade: _____
First Name Last Name

Parent/Legal Guardian Full Name: ____
First Name M.I. Last Name

Address: ____
City State Zip Code

Phone: ___________________________ Email: ____

Parent/Guardian (Legal) Signature: ____

Is your current address a temporary living arrangement? Yes __________ No __________

If yes, is your temporary address due to loss of housing or economic hardship? Yes ______ No ______

Choose best option(s):

The student lives with:	Living situation:
☐ parent(s)/legal guardian(s)	☐ shelter or group home
☐ adult who is NOT parent or legal guardian	☐ relative or friend due to housing/economy loss
☐ no adult; student is unaccompanied adult	☐ motel, car or campsite
☐ other – please specify (in this box below):	☐ family member(s) or friend(s) (other than guardian)

Office Use Only:

☐ Student eligible under McKinney Vento Act ☐ Student not eligible under McKinney Vento Act ☐ Follow Up Required	Additional Notes:

School District of the City of Pontiac
60 Parkhurst St • Pontiac, MI 48342
Phone: (248) 451-6800 • Fax: 248-451-6890
Kelley Williams, Superintendent
"Remembering Your Purpose"

"A World Class School District – We Put Students First"

SCHOOL DISTRICT OF THE CITY OF PONTIAC

MEDIA RELEASE FORM

School: ______________________ School Year: ____________________

Student Name: ____

Grade: _________________ Student ID: ____________________

Occasionally, the commercial media or other approved video, photographic and/or audio production crews may be present at your child's school or Pontiac School District sanctioned activities. If you approve of your child's participation in the video/photographic/audio production, interviews or activities that may take place please print your name and sign below after reading the following:

I, ____, am the parent/guardian of
(Print parent/guardian's name)

the above named student. In the interest of public education, I hereby authorize the Pontiac School District, its Board of Education, the commercial media and non-commercial production crews, acting through their authorized employees or agents and in their discretion to use, re-use, publish, re-publish, post on the internet, and copyright audio and/or visual reproductions of the above named student's voice and/or image, work (art or written material), alone or with other persons, with or without the use of the student's name. I further allow for the supervision and participation of the above-named student in any school activities structured to promote and/or train students of the Pontiac School District.

I also hereby release the Pontiac School District, its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above and waive any request for remuneration.

Signature of Parent/Guardian: ____

Date: __________________________

School District of the City of Pontiac

Consent for Disclosure of 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 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 ______ School District of the City of Pontiac ________ 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: ______________________________ Date: ___/___/___
or Eligible Student

Printed Parent/Guardian Name: __________________________________

School District of the City of Pontiac

Office of Student Services/ Tonya L. Dixson, Director

Request for Educational Records/Transcripts

Previous school: ______________________________ City ____________________

Fax: ______________________ Date: ______________________________

School Enrolling in: ____

- Please send the complete school records, including high school transcripts, test scores, IEP and any other pertinent information that will assist us in enrolling the following student in the School District of the City of Pontiac.

- Please fax transcript, last report card and current schedule to 248-451-7591.

______________________ ______________ ________________

Student Name Present Grade Date of Birth

________________________________ ________________________

Parent/Guardian Name Current Address (Street, City, State, Zip)

Please deliver my student records to:
Office of Student Services
60 Parkhurst Suite #3
Pontiac, MI 48342

I hereby authorize the release of permanent school records and confidential information of my child.

____

Parent/Guardian Signature Date

____

School Official Signature Date

Please note: Under the provisions of the Privacy Rights of Parents and Students Act, Page 1213, Subpart D. 99.30 (b). It is not necessary to have written consent of the parents to release records "to officials of other schools or school system in which student seeks or intends to enroll."

School District of the City of Pontiac

Office of Student Services/ Tonya L. DIxson, Director

Affirmation of Prior Discipline Record

Directions:

Check the applicable paragraph, provide all appropriate information and sign this document.

A willful false statement on this affirmation will result in a report to the appropriate authorities and possible removal from the School District of the City of Pontiac.

Paragraph 1:

_____ The undersigned affirms that ________________________________ has not been suspended or expelled from any public or private school in Michigan or any other state for an offense involving weapons, arson, criminal sexual conduct, physical assault to an employee, volunteer, or a person contracted by the school district, alcohol or drugs or any act of violence against person and/or property committed on school premises, at any school sponsored activity, or on a public or private conveyance providing transportation to and from school or school sponsored activity.

Paragraph 2:

_____ The undersigned affirms that ________________________________ has been suspended or expelled from any public or private school in Michigan or any other state for an offense involving weapons, arson, criminal sexual conduct, physical assault to an employee, volunteer, or a person contracted by the school district, alcohol or drugs or any act of violence against person and/or property committed on school premises, at any school sponsored activity, or on a public or private conveyance providing transportation to and from school or school sponsored activity.

If you checked paragraph 2, explain the circumstances in detail. Include the school name, phone number (if known) dates of suspension or expulsion and a description of the incident giving rise to the suspension or expulsion.

____

____

____

Date: _________________ Signature of Student____

Date: ________________ Signature of Parent/Guardian ____

Name of Sending (former) school district: ____

Address: ____ fax: ___________________

Sending School:

____ According to our records, we can verify that the information provided above by the parent/student is correct.

____ According to our records, we can verify that the information provided above by the parent/student is not correct.

If the student has been suspended or expelled for an offense involving weapons, arson, criminal sexual conduct, physical assault to an employee, volunteer, or a person contracted by the school district, alcohol or drugs or any act of violence against person and/or property committed on school premises, at any school sponsored activity, or on a public or private conveyance providing transportation to and from school or school sponsored activity, please forward appropriate disciplinary documentation.

Date: ___________ Signature of sending District Administrator: ______________________________

Phone number: _____________________ Title of Administrator_________________________________

Pontiac School District
Phone: 248-451-7576

Household Information Survey

SCHOOL USE ONLY
Approved for:
1 ☐ 2 ☐

To determine eligibility for various additional state and federal program benefits that your child(ren) may qualify for, please complete, sign and return this application to your child's school office or the Food Service Office.

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
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

If you need additional lines, attach a second sheet to this survey or attach a copy of this survey 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 No Income
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 - If Income Section is completed, the adult signing the form must also list the last four (4) digits of his or her Social Security Number or check the "I do not have a Social Security Number" box below.

I certify (promise) that all information on this application is true and that all income is reported. I understand that the sponsor will get federal/state funds based on the information I give. I understand that sponsor officials may verify (check) the information.

Sign Here: X______________________ Print Name: ______________________ Date: ______________

Last Four (4) Digits of Adult Social Security Number: XXX-XX-__________ ☐ I do not have a Social Security Number

Address	City	Zip Code

Home Phone	Work Phone	Email Address
		By providing your email address you may be contacted via email by the district

English
Acceptance/Waiver/Refusal of ESL/Bilingual Program

School District of the City of Pontiac

Acceptance or Waiver/Refusal of
English as a Second Language/Bilingual Program

Date: ______________________

Dear Parent or Guardian:

Your child, ____________________________, has been identified as being eligible for an English as a Second Language/Bilingual Program. This determination is based on an assessment of your child's ability to understand, speak, read and write English.

Please fill out the notice below indicating acceptance or refusal of the program and return to the school. If you have any question, please call me at: ______________________________.

Sincerely,

____
Principal or Program Designee

Acceptance or Waiver/Refusal of
English as a Second Language/Bilingual Program

Dear Principal or Program Designee:

☐ I want my child, ______________________, to be placed in the program.

☐ I do not want my child, __________________________, to be placed in the program.

Name of Parent/Guardian: ____________________________ Date: __________________

Signature: ____________________________ Telephone: ________________________

School District of the City of Pontiac
Office of Bilingual and ESL Education
STATE BOARD OF EDUCATION APPROVED

HOME LANGUAGE SURVEY

SCHOOLS MUST COMPLETE THIS SECTION

SCHOOL CODE	LAST NAME, FIRST NAME	ID# IF NO ID# IS AVAILABLE GIVE BIRTH DATE

The School District of the City of Pontiac 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 380.1152-380.1157 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.

Student's Name: ______________________________ Grade: ______ Age: ______

1. Is your child's native tongue a language other than English?

☐ Yes ☐ No What is that language? ______________________

2. Is the primary language[1] used in your child's home or environment a language other than English?

☐ Yes ☐ No What is that language? ______________________

______________________ ______________________ ______________
Signature of Parent or Guardian Address Date

[1]"Primary language" means the dominant language used by a person for communication.

Honor Community Health School Based Health Center
Consent Form for Medical and Dental Services

Student Information							
Last Name		First Name				Middle Initial	
Date of Birth		Social Security Number					
Age		Student Cell Phone #:					
Grade		School					
Address		City		State:		Zip Code	

Parent/Legal Guardian Information			
Last Name		First Name	
Date of Birth		Social Security Number	
Phone #		Preferred Language	

Emergency Contact Information (Complete only if contact is not the same as the parent/guardian)			
Last Name		First Name	
Phone #		Relationship to Student	

Services Provided at the School-Based Health Center

Parental Consent is required for the following services provided to patients under the age of 18:

- Health maintenance Exams
- Treatment for acute and chronic illnesses and injuries
- Oral/dental screenings and follow up
- Basic laboratory services and tests
- Individual, group, family and community education
- Physical exams for school, sports, camp and work
- Vision/hearing screenings and follow up
- Immunizations
- Medication administration
- Referrals for specialty services

Current Michigan law allows for confidential services to minors aged 12 and up. Parental consent is not required for:

- Pregnancy testing
- HIV counseling, testing, and referrals
- Substance abuse education, counseling, and referrals
- Sexually Transmitted Infection screenings, treatment/counseling
- Physical/sexual abuse counseling and referrals
- Crisis intervention and emergency care
- Mental Health and psycho-social assessment, counseling, and referral (must be 14+ to consent)

Services Not Provided at the School-Based Health Center

Per Michigan Law:

- Birth control pills and contraceptive devices are not dispensed or prescribed on school premises
- Abortion counseling, referrals, or services are not provided

Parent/Guardian Consent

I consent to the following:

- The above-named student may receive all services listed above at the School-Based Health Center
- Exchange of healthcare information between the School-Based Health Center and the student's primary care physician and other established healthcare providers for continuity and coordination of care according to state & federal laws
- Release of information regarding treatment to third party payers or others for the purpose of receiving payment for services
- In certain situations, the delivery of care may include telemedicine:
  - My health care provider has explained how the video conferencing technology will be used to affect a consultation. I understand that this consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider
  - I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
  - I understand others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time

By signing this consent form, I confirm that I am the custodial parent and/or legal guardian of the above-named student and the insurance information is current and correct. I understand that I may withdraw my consent or refuse services upon written notice to the health center at any time.

Parent/Guardian Signature		Date:	

Additionally, by checking each box below, I consent to the following:

☐ The above-named student may receive COVID-19 evaluation, testing and treatment by the School-Based Health Center. All students who have received COVID-19 testing through the School-Based Health Center will have results communicated to the parent/guardian as well as school administration prior to returning to school. I understand that positive test results require reporting to the Oakland County Health Department.

☐ Immunizations – I understand my child's immunization records from the Michigan Childhood Immunization Registry (MCIR) will be reviewed. If it is determined that my child needs a shot, I give my permission for it to be given at the School-Based Health Center, and I give permission that the administration of the vaccine be recorded in the MCIR. I understand that I will be able to review a written description of the vaccine and/or talk with a vaccine administrator prior to the vaccine being given.

Primary Insurance Information

Insurance Company		Policy ID		Group/Plan #	
Name of Policy Holder			Relationship to Student		

Secondary Insurance Information

Insurance Company		Policy ID		Group/Plan #	
Name of Policy Holder			Relationship to Student		

Patient Health History

Gender at Birth	☐ Female ☐ Male	Current Gender	☐ Female ☐ Transgender Male (Female to male) ☐ Choose not to disclose ☐ Male ☐ Transgender Female (Male to female) ☐ Other: ______
Sexual Orientation	☐ Straight/Heterosexual ☐ Lesbian or Gay ☐ Bisexual ☐ Something else ☐ Don't Know ☐ Choose not to disclose		
Race	☐ American Indian or Alaska Native ☐ Asian or Pacific Islander ☐ Black or African American ☐ White or Caucasian ☐ More than one race ☐ Other:		
Ethnicity	☐ Hispanic/Latino ☐ Arab ☐ Not Hispanic/Latino ☐ More than one ethnicity	Preferred Language	☐ English ☐ Arabic ☐ Spanish ☐ Other: ______
Living Situation	☐ Not Homeless (Family owns or rents a home/apartment) ☐ Homeless	Are you worried about losing your housing?	☐ Yes ☐ No
Student's Primary Care Doctor		Phone #:	
Student's Dentist		Phone #	
Date of Last Physical	___/___/______	☐ Don't remember	

Current Medications: (please include dosage and reason for taking)

Medication Name: ______________ Dose: ________ Reason: ______________________

Medication Name: ______________ Dose: ________ Reason: ______________________

Allergies	☐ Medication (please list): ______________ ☐ Food (please list): ______________ ☐ Seasonal (hay fever, dust, pollen) ☐ Bee Stings ☐ Other: ______________

Please check if your child has any of the following:

☐ Anemia	☐ Asthma	☐ Attention Deficit Disorder (ADD)	☐ Blood disease
☐ Cancer	☐ Dental Problems: ________	☐ Diabetes	☐ Emotional Impairment or Mental Illness
☐ Fainting	☐ Headaches/Migraines	☐ Head Injury	☐ Heard Murmur
☐ Heart Problems: ________	☐ HIV/AIDS	☐ Hypertension (High blood pressure)	☐ Jaundice
☐ Kidney or Bladder/Urine problem	☐ Liver Disease	☐ Menstrual Problems:	☐ Pregnancy: Due Date:
☐ Rheumatic Fever	☐ Seizures (with or without epilepsy)	☐ Sickle Cell Trait	☐ Sickle Cell Disease
☐ Sinus Problems	☐ Skin Problems	☐ Stomach Problems	☐ Venereal Disease

☐ Other Health Problems: ______________________________

Family Medical History: Please check if any of your child's relatives have had any of the following illnesses and note which relative had them

☐ Asthma	Who: ____________	☐ Hypertension	Who: ____________
☐ Anxiety, depression, or other mental illness	Who: ____________	☐ High Cholesterol	Who: ____________
☐ Cancer	Who: ____________	☐ Kidney Problems	Who: ____________
☐ Death under age 50	Who: ____________	☐ Seizures	Who: ____________
☐ Diabetes	Who: ____________	☐ Sickle Cell Anemia	Who: ____________
☐ Heart Problems	Who: ____________	☐ Stroke	Who: ____________