



School District of the City of Pontiac

Office of Student Services / Tonya L. Dixon - Director

WHAT TO HAVE FOR ENROLLMENT

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. If enrolling online, have documentation available to download. If you are homeless, you do NOT need these forms. Please contact our Homeless Liaison, Wilma Bell, at wilma.bell@pontiacschools.org or 248-451-6868.

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

Enrollment is complete when all the following documents are provided:

- 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- 24-7070
- Special Education Documents - Current **IEP/MET/504** for student receiving special services.



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. Dixon, 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
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Parent/Guardian Name	Current Address (Street, City, State, Zip)
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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
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School Official Signature	Date
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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. Dixon, 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 _____

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 _____



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: _____



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

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

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

<input type="checkbox"/> Asthma	Who: _____	<input type="checkbox"/> Hypertension	Who: _____
<input type="checkbox"/> Anxiety, depression, or other mental illness	Who: _____	<input type="checkbox"/> High Cholesterol	Who: _____
<input type="checkbox"/> Cancer	Who: _____	<input type="checkbox"/> Kidney Problems	Who: _____
<input type="checkbox"/> Death under age 50	Who: _____	<input type="checkbox"/> Seizures	Who: _____
<input type="checkbox"/> Diabetes	Who: _____	<input type="checkbox"/> Sickle Cell Anemia	Who: _____
<input type="checkbox"/> Heart Problems	Who: _____	<input type="checkbox"/> Stroke	Who: _____

PONTIAC SCHOOLS OFFICIAL ENROLLMENT FORM



School & Year: _____

Grade/YOG: _____

PARENT

Student ID#: _____

Entry Date: _____

OFFICE

Please print. Enter student's full name exactly as it appears on their birth certificate

_____	_____	_____	_____	_____
Last Name	First Name	Middle Name	Suffix	Birth Date (mm/dd/yy)

Current Household Information / Student Residence

_____	_____	_____	_____	_____
House #	Street Name	Apt - Box - Lot# Circle 1	Zip Code	Geo Code

_____	_____
City	Preferred Mailing: To send mail to an address other than home address, provide mailing information

Gender (M / F) _____

ETHNICITY: Is this student Hispanic/Latino Ethnicity (Choose Only One):

No, not Hispanic/Latino

Yes, Hispanic/Latino (Cuban, Mexican, Puerto Rican, South or Central American, or other)

RACE: The previous question was regarding ethnicity, not race. No matter what you selected to the left, please answer the following by marking one or more boxes to indicate what you consider your student's (or your) race to be:

American Indian Asian Black/African American

Native Hawaiian/Other Pacific Islander White

HOME LANGUAGE

Do you speak a language in your home **OTHER** than English?

YES NO

If Yes, please note the language: _____

STUDENT PRIMARY LANGUAGE

Does your student speak a language in your home **OTHER** than English?

YES NO

If Yes, please note the language: _____

LEGAL BINDINGS: Please indicate any special circumstances regarding your child:

Home Phone w/Area Code _____

Type— Resident/Cell Etc. _____

Unlisted Message Only

Entry Comment

Indicate District / School name & state of last school attended, and whether the student had an active IEP:

Has your child attended Pontiac Schools? ___ YES ___ No

Did your child have an active IEP? ___ YES ___ No

Do you have any other children in your household enrolled at Pontiac Schools? If so, please list their names below:

As the parent/legal guardian, my signature to the right, affirms all information provided within this form is true and accurate, and that my child and I reside at the listed address. I understand false information provided by me, may subject me to legal penalties for perjury.

Parent Signature _____ Date _____

VERIFICATION CHECKLIST - FOR OFFICE USE ONLY

Birth Certificate: _____ - Other Proof & Affidavit: _____	Custody Verification: _____ (If Applicable)
Residency Verification: _____ (Determinative / Corroborative Type)	HmRm # / Teacher: _____ or Counselor: _____
- Affidavit of Student Living w/Relative: _____	- Affidavit of Family Living w/ Friend/Relative: _____
Immunization Record: _____	Verified / Entered By: _____
Homeless: _____ (File paperwork w/Enrollment Office)	Verifier Title: _____

PONTIAC SCHOOLS OFFICIAL ENROLLMENT FORM

OFFICE **PARENT**

Membership	District of Residence (Not= 63030) & Residency Code	Birthplace as appears on Birth Certificate: List city of birth <i>**If city unknown—enter state. **If state unknown—enter country</i>

Citizenship (Not=USA)	Track & Year	Status (AF/M/P)	Entry Date	Entry Code	Grade	Registration Date (Misc. Tab)	FTE if < 1

Restrictions/Publications: What data can be shared / used by the district?

All Data / All Photos
 All Data / No Photos
 No Data / All Photos
 No Data / No Photos

With Whom Does Your Child Reside?

Both parents
 Mother Only
 Father Only
 Mother/Stepfather
 Guardian(s)
 Foster Parent(s)
 Father/Stepmother
 Other: _____

Student Email Address

Contacts — Male / Guardian of Student (In Same Household Only)

Last Name	First Name	Middle Name & Suffix (Jr, III, etc.)

Lives with Student? Yes, my address is the same as my child. If no, list address to the right.
 Y / N

Street Number & Name	Apt/Lot # etc.	City, State	Zip

Area Code	Primary / Home Phone	Area Code	Cell	Area Code	Work Phone

Male Parent / Guardian Email Address (General Tab)	Relationship to Student (Father, Stepfather, etc.)

Contacts — Female / Guardian of Student (In Same Household Only)

Last Name	First Name	Middle Name & Suffix (Jr, III, etc.)

Lives with Student? Yes, my address is the same as my child. If no, list address to the right.
 Y / N

Street Number & Name	Apt/Lot # etc.	City, State	Zip

Area Code	Primary / Home Phone	Area Code	Cell	Area Code	Work Phone

Female Parent/Guardian Email Address (General Tab)	Relationship to Student (Mother, Stepmother, etc.)

PONTIAC SCHOOLS OFFICIAL ENROLLMENT FORM

Parent Living Elsewhere

PARENT

OFFICE

Complete the section below if the Shared or Non-custodial parent lives in a home other than the student.

Last Name	First Name	Middle Name & Suffix (Jr, III, etc.)

Street Number & Name	Apt/Lot # etc.	City, State	Zip

Area Code	Primary / Home Phone	Area Code	Cell	Area Code	Work Phone

Parent Elsewhere / Guardian Email Address (General Tab)	Relationship to Student (Mother, Father, etc.)

Other Adult Contacts

1

Last Name	First Name	Relationship to Student (Relative, Neighbor, etc.)

Street Number & Name	Apt/Lot # etc.	City, State	Zip

Area Code	Primary / Home Phone	Area Code	Cell	Area Code	Work Phone

2

Last Name	First Name	Relationship to Student (Relative, Neighbor, etc.)

Street Number & Name	Apt/Lot # etc.	City, State	Zip

Area Code	Primary / Home Phone	Area Code	Cell	Area Code	Work Phone

Emergency Information - Physician / Insurance information is optional and will only be used in cases of emergency.

List Health Alert Information (Health Module)

List medical conditions (allergies, health conditions etc.) or other information which you want teachers and office personnel to know. This information when entered, will be available for teachers to see in class on a secure desktop application.

This is a critical alert item

By listing this information here, I agree to share this information with school officials. Parent/Guardian Initials _____

--

First and Last Name of Physician (Include phone number)

--

Preferred Hospital (include city where hospital is located)

--

Family Insurance Provider

--

Insurance Policy Number