

**SCHOOL OF CHOICE APPLICATION**

**2024-2025**

Please return before August 16, 2024

To: Superintendent  
Union City Community Schools  
430 St. Joseph Street  
Union City, Michigan 49094

Student's Name: \_\_\_\_\_ Grade Applying For: \_\_\_\_\_

Last Grade Completed: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent(s)/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_

District of Residence: \_\_\_\_\_

School Attended Last Year: \_\_\_\_\_

Suspended/Expelled within last two years: \_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes, please explain the reason: \_\_\_\_\_

\_\_\_\_\_

Special Education Services: \_\_\_\_\_ Yes \_\_\_\_\_ No

Reason for requesting School of Choice: (In submitting request, state specific reason(s) and **all** special needs of your child)

\_\_\_\_\_

\_\_\_\_\_

**Sibling Information:**

Does the applicant have a sibling(s) attending Union City Schools? \_\_\_\_\_ Yes  
\_\_\_\_\_ No

Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Name: \_\_\_\_\_ Grade: \_\_\_\_\_

**\*\*NOTE\*\***

**PROVIDING FALSE OR MISLEADING INFORMATION ON THIS DOCUMENT WILL BE GROUNDS FOR IMMEDIATE REMOVAL FROM THE DISTRICT.**

**PARENTS WILL BE RESPONSIBLE FOR TRANSPORTATION OF STUDENT(S) FOR INCOMING SCHOOL OF CHOICE STUDENTS.**

**STUDENTS WHO TRANSFER BY CHOICE FROM ONE SCHOOL TO ANOTHER AND DO NOT OTHERWISE SATISFY THE M.H.S.A.A. TRANSFER REGULATIONS ARE INELIGIBLE FOR INTERSCHOLASTIC ATHLETICS FOR A FULL SEMESTER.**

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\*

*For Office Use Only*

Date Application Received: \_\_\_\_\_

Application Approved: \_\_\_\_\_

Application Denied: \_\_\_\_\_ Reason:  
\_\_\_\_\_

Applicant/Parent Notified on: \_\_\_\_\_