

**THE GROSSE POINTE PUBLIC SCHOOL SYSTEM**

20601 Morningside Drive  
Grosse Pointe Woods, MI 48236  
313-432-3083 313-432-3031 (fax)  
www.gpschools.org

**Registration/Enrollment Checklist**

Your child is not officially enrolled in Grosse Pointe Public Schools until your residency is verified and you submit the required enrollment documentation.

**ALL RESIDENCY AND ENROLLMENT DOCUMENTATION SHOULD BE PROCESSED  
ONLINE**

**PAPERWORK WILL NOT BE ACCEPTED AT THE SCHOOL**

*Please upload the following documentation:*

- Residency Verification Documentation (list attached)
- Completed Enrollment Packet
  - Enrollment Form
  - Emergency Form
  - Home Language Survey
  - Communication Release Forms
- Original Birth Certificate\*
  - Copies made for CA-60 – original documents returned
- Immunization Record(s)\*/Health Appraisal Form\*
  - Copies made for CA-60 – original documents returned
- Early Intervention/Special Education paperwork (if applicable)
- Court Documents (if applicable) (Custody Paperwork, Guardianship)

Enrollment Office Hours are:  
Monday-Thursday 8am – 4pm / Friday 8am – 3:30pm

## **MANDATORY RESIDENCY VERIFICATION**

You need the following documents\* to verify your residency or change your address:

1. Driver's License or State ID (Showing current address in district)

2. Current: ONE of:

Homeowners (one of these):

Closing statement (if less than 12 months old) *or*;

Current Property Tax Bill *or*;

Current Mortgage statement

Renters (one of these):

Current Lease with expiration *or*;

Landlord Affidavit

3. TWO bills (i.e., bank statement, utility, cable, renters/homeowners insurance, credit card, cell phone, car registration)

4. Car Insurance with Current Address

**\*ALL DOCUMENTS MUST BE ORIGINAL**

**Enrollment Office**

**20601 Morningside Drive, Grosse Pointe Woods 48236**

**313-432-3083**

**Hours: 8:00 am - 4:00 pm Monday - Thursday and 8:00 am - 3:30 pm on Friday**

# Grosse Pointe Public Schools Early Childhood Enrollment Questionnaire

The following questions are so that we can best understand your child.  
Please fill out this questionnaire before your child's screening.

## Child's Information

Legal Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

A. Is child's **ethnicity** Hispanic or Latino? Yes  or No

B. **Race:** American Indian/Alaskan Native  Asian  White

Black/African American  Native Hawaiian/Other Pacific Islander

**Both Parts A & B must be completed.** We encourage you to select an answer for both parts. If either Part A or B is not answered, the US Department of Education **requires** the school district to supply an answer on your behalf. You may select more than one race designation.

## Parent Information

Mother's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email Address \_\_\_\_\_

Father's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email Address \_\_\_\_\_

## Family History

Child lives with:

Both Parents  Mother  Father  Mother and Stepfather

Father and Stepmother  Legal Guardian  Other (please specify) \_\_\_\_\_

Is the child adopted?  Yes  No Child's age at adoption \_\_\_\_\_

Status of parents' marriage:

Married  Separated  Divorced  Widowed  Single

Primary language spoken in the home: \_\_\_\_\_

**THE GROSSE POINTE PUBLIC SCHOOL SYSTEM EMERGENCY INFORMATION/AUTHORIZATION FOR EMERGENCY TREATMENT**

STUDENT MAY NOT REGISTER UNLESS THIS FORM IS COMPLETED AND SIGNED BY PARENT/GUARDIAN

Student Last Name	Student First Name	Gender	Date of Birth	Area Code & Phone #
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Student Home Address	City	State	Zip	Grade	School
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If Parents are divorced: \_\_\_\_\_  
 Legal Custody(Mother/Father/Both)                      Physical Custody(Mother/Father/Both)                      If specific instructions or restrictions apply, attach Court Order/Judgment

Persons to call in the event of an emergency. If we are unable to contact the student's parent/guardian, the other contacts listed may be called and will assume temporary care of the student. Please ensure that information listed below is accurate.                      Please note: STUDENT WILL NOT BE RELEASED TO PERSONS WITHOUT IDENTIFICATION.

Father/Guardian Name	Complete Home Address (if different from above)	email address
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AC & Home Phone #	AC & Cell Phone # (1)	AC & Cell Phone # (2)	AC & Work Phone # (1)	AC & Work Phone # (2)
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Mother/Guardian Name	Complete Home Address (if different from above)	email address
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AC & Home Phone #	AC & Cell Phone # (1)	AC & Cell Phone # (2)	AC & Work Phone # (1)	AC & Work Phone # (2)
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Emergency Contact Name	Relationship	AC & Home Phone#	AC & Cell Phone#	AC & Work Phone#
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Emergency Contact Name	Relationship	AC & Home Phone#	AC & Cell Phone#	AC & Work Phone#
------------------------	--------------	------------------	------------------	------------------

Emergency Contact Name	Relationship	AC & Home Phone#	AC & Cell Phone#	AC & Work Phone#
------------------------	--------------	------------------	------------------	------------------

Emergency Contact Name	Relationship	AC & Home Phone#	AC & Cell Phone#	AC & Work Phone#
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If your child needs any medications (over the counter or prescription) administered during school time, be sure to fill out *Permission to Administer Medication* Form and speak with school personnel.

Has your child had any serious accidents, illnesses or operations that might limit activity? No _____ Yes: _____	<u>Allergies:</u> Medications _____ Food _____ Insects _____ Other _____	<u>Medical Conditions:</u> Asthma _____ Diabetes _____ Blood Abnormality _____ Cardiac _____ Other: _____	<u>Does your Child Require any of these items be kept at school?</u> Asthma Inhaler _____ Peak Flow Meter _____ Blood Sugar Test _____ Other: _____ Epi Pen _____
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Physician's Name	Physician's AC & Phone #	Dentist's Name	Dentist's AC & Phone #	No	Yes
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Medical/Hospital Insurance Co	Subscriber's Name	Contract #	Group #	Service Code
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I/We the parent or legal guardian of the above named student at Grosse Pointe Public Schools hereby delegate to any teacher or administrator of the Grosse Pointe Public School System who has responsibility of supervising him/her, the authority to authorize and consent to any and all emergency medical, surgical, dental or hospital care or treatment while he/she is a student at school and/or on an educational field trip. Such treatment is to be rendered by, or under the supervision of, a licensed physician or dentist. Such teacher or administrator is fully authorized to act in accordance with his/her judgment in any such emergency and is absolved from any liability or financial responsibility to connection therewith. Your signature below indicates that the information on this form is correct. If the school is unable to contact a parent or guardian, we are authorized to release your child to the emergency contact listed. In case of a medical emergency at school, the parent, guardian or designee listed on this form is required to meet and transport the student home. When judged necessary, an EMS may be called and may transport the student to a local hospital. (The local government may charge a fee for ambulance service; **if required in an emergency, you may be charged. Grosse Pointe Public Schools will not be responsible for such charges.**)

Signature of Parent/Guardian \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_

# HEALTH APPRAISAL

**Dear Parent or Guardian:** The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. **(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION.)**

## PERSONAL

CHILD'S NAME (Last, First, Middle)			DATE OF BIRTH (mm/dd/yy) / /
ADDRESS (Number & Street)	(City)	(ZIP Code)	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER ( )
ADDRESS (Number & Street)	(City)	(ZIP Code)	WORK TELEPHONE NUMBER ( )

## SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)	<b>Birth History:</b>  Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:  If yes, list medications:  Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Examiner's Initials:</b> _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2 Hay Fever, Asthma, or Wheezing	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3 Eczema or Frequent Skin Rashes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4 Convulsions/Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 Heart Trouble	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6 Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8 Trouble with Passing Urine or Bowel Movements	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9 Shortness of Breath	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10 Speech Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11 Menstrual Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12 Dental Problems: Date of Last Exam / /	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe): _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child take any medication(s) regularly?	
			Reason for Medication	
			_____ / /	
			<b>Parent/Guardian Signature</b> _____ Date _____	

## SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

### Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	VISION Date: / /	Visual Acuity Muscle Imbalance Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT Other: _____	Height Weight Other: _____			
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: / /	Audiometer Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE	Reading: _____			
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: / /	Sugar Albumin Microscopic				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN	Type: _____ Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm			
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl				<b>NOTE:</b> Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.						

### Examinations and/or Inspections

Essential Findings Deviating from Normal:
Exam Date: / /

**SECTION III - IMMUNIZATIONS**

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.\*

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	2
	2			2	3
DTaP/DTP/DT/Td	1	4	Influenza (IIV/LAIV)	1	4
	2	5		2	4
	3	6			
Tdap	1		Meningococcal (MCV4 / MPSV4)	1	2
Haemophilus Influenzae type b (HIB)	1	3	Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	2	4		2	
Polio (IPV/OPV)	1	3	OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	2	4		1	
				2	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	3		
Rotavirus (RV1/RV5)	1	3	<i>Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable</i>		
	2		*NOTE: According to Public Act 368 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 the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your provider office for medical waiver forms and through your local health department for nonmedical waiver forms.		
Measles, Mumps, Rubella (MMR)	1	2	Parent/Guardian refused immunizations: <input type="checkbox"/>		
Varicella (Chickenpox)	1	2			
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____					
I certify that the immunization dates are true to the best of my knowledge					
_____			_____		____/____/____
<i>Health Professional's Signature</i>			Title		Date

**SECTION IV - RECOMMENDATIONS**

(Required for Child Care and Head Start/Early Head Start)

No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain:
<input type="checkbox"/>	<input type="checkbox"/>	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> Other
Other Recommendations		

**SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)**

I have examined \_\_\_\_\_'s teeth. As a result of this examination, my recommendation for treatment is: \_\_\_\_\_

child's name

\_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

*Dentist's Signature* Date

**PHYSICIAN'S SIGNATURE**

\_\_\_\_\_

*Examiner's Signature* Date *Examiner's Name (Print or Type)* Degree or License

\_\_\_\_\_ MI \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Number & Street City ZIP Code Telephone

Information required for:

**Early On** - Hearing and Vision Status; Diagnosis; Health Status

**Child Care Licensing** - Physical Exam, Restrictions, Immunizations

**Head Start/Early Head Start** - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-child care visit required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.

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Developed in Cooperation with the Department of Health and Human Services, Education, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.

**Form for Directory Information (to be adapted for use electronically)**

The Family Educational Rights and Privacy Act (“FERPA”) requires that the School System annually give public notice to parents and eligible students about student information it considers “directory information.” Under FERPA, directory information about students may be released by the District without parental consent unless the parent has elected not to permit the release of such information. Under Board Policy 8330, the District has designated as “directory information” the following information about students:

- name;
- participation in officially recognized activities and sports;
- height, if a member of an athletic team;
- weight, if a member of an athletic team which requires disclosure to participate;
- grade level, and date of actual or expected graduation;
- awards or honors received;
- photographs;
- videos of students participating in school activities, events or programs; and

If you **do not** want to have directory information about your student made available, please check the box below.

\_\_\_ I do not want to have any “directory information,” as described above, about my student disclosed.

## Permission for Publishing on Grosse Pointe Public School Sponsored Media)

Throughout the year, our students and staff have been highlighted in local newspapers, advertisements of district offerings, school newsletters, our local cable station, and the website. Students often enjoy seeing themselves and their classmates in these. Examples of events where this might occur include concerts, field trips, visits by authors, and fun classroom or family activities.

The district requires that children and parents of minors grant permission - through a signed release - for the school or district to display **students' names, photos, video image, audio recording, or work on district web sites, printed materials, or video pieces. Printed materials include programs for Honors Night, concerts and plays.** If you should change your decision on this while your child is a student in the district, you will be required to file a new copy of this form with the school office.

### What **CAN** be published **INTERNALLY** or **EXTERNALLY** when permission is granted:

- Student's first and last name without picture.
- Student's picture or video image without name.
- Student's work with name (no picture).

**EXTERNAL publications** include press releases, advertisements, and coverage in local papers and television, for school-related activities, including those of the Grosse Pointe Foundation for Public Education.

If you **DO NOT** want publishing permissions for your child, you may have it excluded from release by checking the box below.

Publishing Permission: **I DO NOT GIVE** the Grosse Pointe Public School System permission to use my child's first and last name, photograph, video image, and/or work on press releases and other external communication.

Child's Name: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

# Educational Material for Parents and Students (Content Meets MDCH Requirements)

Sources: Michigan Department of Community Health, CDC and the National Operating Committee on Standards for Athletic Equipment (NOCSAE)

## UNDERSTANDING CONCUSSION

### Some Common Symptoms

Headache  
Pressure in the Head  
Nausea/Vomiting  
Dizziness

Balance Problems  
Double Vision  
Blurry Vision  
Sensitive to Light

Sensitive to Noise  
Sluggishness  
Haziness  
Fogginess  
Grogginess

Poor Concentration  
Memory Problems  
Confusion  
“Feeling Down”

Not “Feeling Right”  
Feeling Irritable  
Slow Reaction Time  
Sleep Problems

### 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 fall, bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. A concussion can be caused by a shaking, spinning or a sudden stopping and starting of the head. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious. A concussion can happen even if you haven’t been knocked out.

You can’t see a concussion. Signs and symptoms of concussions can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If the student reports any symptoms of a concussion, or if you notice symptoms yourself, seek medical attention right away. A student who may have had a concussion should not return to play on the day of the injury and until a health care professional says they are okay to return to play.

### IF YOU SUSPECT A CONCUSSION:

- 1. SEEK MEDICAL ATTENTION RIGHT AWAY** – A health care professional will be able to decide how serious the concussion is and when it is safe for the student to return to regular activities, including sports. Don’t hide it, report it. Ignoring symptoms and trying to “tough it out” often makes it worse.
- 2. KEEP YOUR STUDENT OUT OF PLAY** – Concussions take time to heal. Don’t let the student return to play the day of injury and until a health care professional says it’s okay. A student who returns to play too soon, while the brain is still healing, risks a greater chance of having a second concussion. Young children and teens are more likely to get a concussion and take longer to recover than adults. Repeat or second concussions increase the time it takes to recover and can be very serious. They can cause permanent brain damage, affecting the student for a lifetime. They can be fatal. It is better to miss one game than the whole season.
- 3. TELL THE SCHOOL ABOUT ANY PREVIOUS CONCUSSION** – Schools should know if a student had a previous concussion. A student’s school may not know about a concussion received in another sport or activity unless you notify them.

### SIGNS OBSERVED BY PARENTS:

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

### 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 s/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/places
- Becomes increasingly confused, restless or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously.)

### HOW TO RESPOND TO A REPORT OF A CONCUSSION:

If a student reports one or more symptoms of a concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of athletic play the day of the injury. The student should only return to play with permission from a health care professional experienced in evaluating for concussion. During recovery, rest is key. Exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse. Students who return to school after a concussion may need to spend fewer hours at school, take rests breaks, be given extra help and time, spend less time reading, writing or on a computer. After a concussion, returning to sports and school is a gradual process that should be monitored by a health care professional.

Remember: Concussion affects 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.

To learn more, go to <http://www.cdc.gov/headsup>.

**Parents and Students Must Acknowledge this Information**

# CONCUSSION AWARENESS

## EDUCATIONAL MATERIAL ACKNOWLEDGEMENT FORM

By my name and signature below, I acknowledge in accordance with Public Acts 342 and 343 of 2012 that I have received and reviewed the Concussion Fact Sheet for Parents and/or the Concussion Fact Sheet for Students provided by \_\_\_\_\_

\_\_\_\_\_  
Sponsoring Organization

\_\_\_\_\_  
Participant Name Printed

\_\_\_\_\_  
Parent or Guardian Name Printed

\_\_\_\_\_  
Participant Name Signature

\_\_\_\_\_  
Parent or Guardian Name Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

Return this signed form to the sponsoring organization that must keep on file for the duration of participation or age 18.

Participants and parents please review and keep the educational materials available for future reference.

## Language Form

Is English the primary language spoken in the home?  Yes  No

If no, what language is spoken in the home? \_\_\_\_\_

Child's Name: \_\_\_\_\_

Parent Signature: \_\_\_\_\_