



**Rogers City Area Schools  
Rogers City Elementary School  
532 West Erie Avenue  
Rogers City, Michigan 49779  
PH: (989) 734-9150 FAX: (989) 734-9165**

## **ENROLLMENT INFORMATION**

Documentation required for enrollment in Rogers City Area Schools is listed below.  
Documentation must be received prior to the first day attending school.

- ☐ **Rogers City Area Schools' Application for Enrollment**
- ☐ **Child's original certified birth certificate**, as required by state law
- ☐ **Proof of residency** – we will accept only the documents listed below as proof of residency
  - Parent/guardian driver's license with current address, or
  - Current lease/rental agreement and a current utility/telephone bill
- ☐ **Parent/guardian picture identification**
- ☐ **Immunization records**
- ☐ **Vision & hearing screening results**, as required by state law
- ☐ **Guardianship/custody order**, if applicable -If there are custody restrictions on a divorce decree or court order, please bring that documentation with you at the time of enrollment.

**Your child is not officially enrolled and may not attend school until all of the required documentation has been submitted.**

Rogers City Area Schools Board of Education Policies and our school handbook may be reviewed at our school website at [www.rcas.k12.mi.us](http://www.rcas.k12.mi.us) or by contacting the school office.

### **Kindergarten Enrollment:**

A child is eligible for kindergarten if he or she will be 5 years of age on or before September 1<sup>st</sup> of the upcoming school year.

Your kindergarten registration appointment is scheduled for

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Please complete and return enrollment forms prior to your scheduled registration day or plan to arrive 15 minutes early on the day of your appointment.



# Rogers City Area Schools

1033 West Huron Avenue, Suite B, Rogers City, MI 49779

## Enrollment Application

### Student Legal Information

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ City/State of Birth: \_\_\_\_\_  
Gender: ☐ Male ☐ Female Grade enrolling in: \_\_\_\_\_ Previously enrolled in Rogers City Area Schools: ☐ Yes ☐ No

### Student's Primary Residence

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Primary Phone Number: \_\_\_\_\_ Busing Requested: ☐ Yes ☐ No  
Student Lives With: (Please check) ☐ Both natural parents ☐ Father ☐ Mother ☐ Relative  
☐ Legal guardian ☐ Foster ☐ Other (explain) \_\_\_\_\_

**\*\*If student does not live with both natural parents, custody order must be provided to school.\*\***

Mother Legal Name		Father Legal Name	
Maiden Name			
Home Address		Home Address	
Home Phone #		Home Phone #	
Marital Status		Marital Status	
Lives with Student?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lives with Student?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employer		Employer	
Work #		Work #	
Cell #		Cell #	
Email		Email	

**Please complete Stepmother/Stepfather information if applicable:**

Stepmother Name		Stepfather Name	
Lives with Student?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lives with Student?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employer		Employer	
Work #		Work #	
Cell #		Cell #	

Guardian/Foster Caregiver Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

### Student's Ethnic and Language Information

**Part A:** Is the student of Hispanic/Latin Descent? ☐ Yes ☐ No

*(A person of Cuban, Mexican, Puerto Rican, South or Central America or other Spanish origin regardless of race)*

**Part B:** Student's Race (choose one or more) ☐ American Indian or Alaskan ☐ Caucasian ☐ Asian  
☐ Arab American ☐ African American/Black ☐ Native Hawaiian/Pacific Islander

*Both parts A and B must be completed. We encourage you to select an answer for both parts. If either part is not completed, the US Dept. of Education requires the school district to supply an answer on your behalf.*

Student's Primary Language: English ☐ Yes ☐ No If no, what language is primary? \_\_\_\_\_

### Previous School Information (Please list last school attended including pre-kindergarten)

Name: \_\_\_\_\_ Last Day: \_\_\_\_\_ Year(s) Attended: \_\_\_\_\_ Grade(s): \_\_\_\_\_  
Address: \_\_\_\_\_ City/State: \_\_\_\_\_

Is there a current IEP for Special Education Services or 504 Plan: ☐ Yes ☐ No

If yes, for what services? \_\_\_\_\_

Has the student had a suspension or expulsion from any school district: ☐ Yes ☐ No

**Please continue to page 2 of this Enrollment Application**





# Rogers City Area Schools

1033 West Huron Avenue, Suite B, Rogers City, MI 49779

## Enrollment Application - Page 2

Student Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

### Sibling Information

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ School attending: \_\_\_\_\_  
\_\_\_\_\_

### Additional Student Information

Student is living in a household with a person who has served or is serving in the military. ☐ Yes ☐ No

Name of military personnel: \_\_\_\_\_

Student Residence is: (please check one)

\_\_\_\_\_ Single family in a house or dwelling

\_\_\_\_\_ More than one family in a house or dwelling

\_\_\_\_\_ Hotel/Motel

\_\_\_\_\_ Transitional housing or other (please describe)

\_\_\_\_\_ Shelter

\_\_\_\_\_ Lives with friend or relative, other than parents or guardians

\_\_\_\_\_ Unsheltered

### Medical Information

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

### Parent/Guardian Information and Authorization

In case of emergency, I hereby authorize school officials to provide first aid and/or seek medical treatment from emergency services. The parent(s)/guardian(s) are responsible for all expenses incurred. My signature below authorizes emergency medical care for my child and release of medical condition(s) to school administration personnel.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I have provided my child's original certified birth certificate.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I am not able to produce a certified birth certificate for the following reasons:

I am able to provide reliable proof of my student's identity and age with the following documents:

\_\_\_\_\_ Baptismal Certificate

Other \_\_\_\_\_

\_\_\_\_\_ Court Records

\_\_\_\_\_ Passport or Immigration Record

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I verify that all statements made in this application are true and accurate. I understand that if at any time a misrepresentation of these facts is discovered, my child will be released immediately to his/her home school, or the undersigned agrees to accept responsibility for full payment of tuition, at the state per pupil foundation rate. I also give permission for Rogers City Area Schools to contact previous school(s) for verification of information included in this application. I have been informed of my rights under FERPA.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Office Use Only:

Birth Cert:

Immun:

Lic:

SOC:

IEP:

SE:

## 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)
	MI	
PARENT/GUARDIAN (Last, First, Middle)		TODAY'S DATE (mm/dd/yy)
		/ /
		HOME TELEPHONE NUMBER
		( )
ADDRESS (Number & Street)	(City)	(ZIP Code)
	MI	
		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)
<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"/>		Does your child take any medication(s) regularly?
Reason for Medication _____ _____			
_____ _____ <b>Parent/Guardian Signature</b> /      / Date			



➔

Birth History:
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> _____

## 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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT Other: _____	Height Weight Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: ____/____/____	Audiometer Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE	 Reading: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: ____/____/____	Sugar Albumin Microscopic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN Date: ____/____/____	Type: _____ Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<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

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		Influenza (IIV/LAIV)	1	3
				2	4
DTaP/DTP/DT/Td	1	4	Meningococcal (MCV4 / MPSV4)	1	2
	2	5	Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	3	6		2	
Tdap	1		OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
Haemophilus Influenzae type b (HIB)	1	3		1	
	2	4		2	
Polio (IPV/OPV)	1	3		3	
	2	4	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable		
Pneumococcal Conjugate (PCV7/PCV13)	1	3	*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.		
	2	4			
Rotavirus (RV1/RV5)	1	3			
	2		Parent/Guardian refused immunizations: <input type="checkbox"/>		
Measles, Mumps, Rubella (MMR)	1	2			
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					
_____ Health Professional's Signature			_____ 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 _____ child's name	's teeth. As a result of this examination, my recommendation for treatment is: _____
_____ Dentist's Signature	
_____ Date	

**PHYSICIAN'S SIGNATURE**

_____ Examiner's Signature	_____ Date	_____ Examiner's Name (Print or Type)	_____ Degree or License
_____ Number & Street	_____ City	_____ MI	_____ 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.

\*\*\*\*\*

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.

## ***Rogers City Area School District***

### **Consent for Disclosure of Personally Identifiable Information and 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 and immunization 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.

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*I authorize \_\_\_\_\_ Rogers City Area School District \_\_\_\_\_ to release my child's immunization record and personally identifiable information 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  
or Eligible Student: \_\_\_\_\_ Date: \_\_/\_\_/\_\_

Printed Parent/Guardian Name: \_\_\_\_\_



## Food Allergy Assessment Form

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**If your child has NO known food allergy, please sign here:**

**If your child HAS food allergy, please complete the entire form below.**

Health Care Provider (name) treating food allergy: \_\_\_\_\_ Phone: \_\_\_\_\_

Do **you think** your child's food allergy may be **life-threatening**?  
(If YES, please see the school nurse as soon as possible).

☐ No ☐ Yes

Did your student's **health care provider tell you** the food allergy may be **life-threatening**?  
(If YES, please see the school nurse as soon as possible.)

☐ No ☐ Yes

### History and Current Status

Check the foods that have caused an allergic reaction:

- |   |   |                               |
|---|---|-------------------------------|
| <input type="checkbox"/> Peanuts              | <input type="checkbox"/> Fish/shellfish                             | <input type="checkbox"/> Eggs |
| <input type="checkbox"/> Peanut or nut butter | <input type="checkbox"/> Soy products                               | <input type="checkbox"/> Milk |
| <input type="checkbox"/> Peanut or nut oils   | <input type="checkbox"/> Tree nuts (walnuts, almonds, pecans, etc.) |                               |

Please list any others: \_\_\_\_\_

How many times has your student had a reaction? ☐ Never ☐ Once ☐ More than once, explain: \_\_\_\_\_

When was the last reaction? \_\_\_\_\_

Are the food allergy reactions: ☐ staying the same ☐ getting worse ☐ getting better

### Triggers and Symptoms

What has to happen for your student to react to the problem food(s)? *(Check all that apply)*

☐ Eating foods ☐ Touching foods ☐ Smelling foods ☐ Other, please explain: \_\_\_\_\_

What are the signs and symptoms of your student's allergic reaction? *(Be specific; include things the student might say.)*

How quickly do the signs and symptoms appear after exposure to the food(s)?

\_\_\_\_ Seconds    \_\_\_\_ Minutes    \_\_\_\_ Hours    \_\_\_\_ Days

### Treatment

Has your student ever needed treatment at a clinic or the hospital for an allergic reaction?

☐ No ☐ Yes, explain: \_\_\_\_\_

Does your student understand how to avoid foods that cause allergic reactions? ☐ Yes ☐ No

What treatment or medication has your health care provider recommended for use in an allergic reaction?

Have you used the treatment? ☐ No ☐ Yes

Does your student know how to use the treatment? ☐ No ☐ Yes

Please describe any side effects or problems your child had in using the suggested treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**If you intend for your child to eat school provided meals, have you filled out a diet order form for school?**

- ☐ Yes.  
☐ No, I need to get the form, have it completed by our health care provider, and return it to school.

**If medication is to be available at school, have you filled out a medication form for school?**

- ☐ Yes.  
☐ No, I need to get the form, have it completed by our health care provider, and return it to school.

**If medication is needed at school, have you brought the medication/treatment supplies to school?**

- ☐ Yes.  
☐ No, I need to get the medication/treatment and bring it to school.

What do you want us to do at school to help your student avoid problem foods? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I give consent to share, with the classroom, that my child has a life-threatening food allergy.**

- ☐ Yes.  
☐ No.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by R.N.: \_\_\_\_\_ Date: \_\_\_\_\_



**ROGERS CITY AREA SCHOOLS**  
**1033 W. Huron Avenue, Suite B, Rogers City, MI 49779**  
**(989) 734-9100**

## Request for Student Transportation by Bus

Transportation between home and school will be provided for each resident child within our established bus routes. The Board of Education reserves the right to terminate transportation based on District financial, legal, or other considerations. It is a privilege for students to ride a District vehicle and this privilege may be revoked if the student's conduct is in violation of the Administrative Guidelines or the Code of Conduct pertaining to student transportation. It is understood that the student will have one primary pick-up and drop-off location as determined by the District. Alternate arrangements on an urgent or emergency basis only may be accommodated if provided in writing to the school office or by contacting the school office. Without notification of this manner, your student will be transported to and from your primary location. ***It is the responsibility of the parent or guardian to ensure that students are safe and supervised upon drop-off. It is the responsibility of the parent or guardian to notify the school office immediately upon change of address or contact information.***

Name of Student(s): \_\_\_\_\_ Grade: \_\_\_\_\_  
Name of Student(s): \_\_\_\_\_ Grade: \_\_\_\_\_  
Name of Student(s): \_\_\_\_\_ Grade: \_\_\_\_\_  
Name of Student(s): \_\_\_\_\_ Grade: \_\_\_\_\_  
**Student HOME address:** \_\_\_\_\_  
**Starting Date:** \_\_\_\_\_

**Primary Pick-up and Drop-off Address:** \_\_\_\_\_

Pick-up Days: Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐  
Drop-off Days: Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐

Description of Location (i.e. color of house, closest roads intersecting, etc.):

Name of primary adult(s) at this residence: \_\_\_\_\_ Relationship to student: \_\_\_\_\_  
Phone number at residence: \_\_\_\_\_

**One Alternate Address Approved for Pick-up/Drop-Off:** \_\_\_\_\_

Pick-up Days: Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐  
Drop-off Days: Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐

Description of Location (i.e. color of house, closest roads intersecting, etc.):

Name of primary adult(s) at this residence: \_\_\_\_\_ Relationship to student: \_\_\_\_\_  
Phone number at residence: \_\_\_\_\_

Printed Name of Parent/Guardian(s): \_\_\_\_\_

Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

*doc/bus/req for transp*

Office Use: ☐ New enroll ☐ Sibling add

Primary Bus Assigned \_\_\_\_\_ Alternate Bus Assigned \_\_\_\_\_

# ROGERS CITY AREA SCHOOLS

532 West Erie Avenue, Rogers City, Michigan 49779  
(989) 734-9150, fax (989) 734-9165

## REQUEST FOR TRANSFER OF STUDENT RECORDS

Rev: 06/18

STUDENT NAME: \_\_\_\_\_  
(Last) (First) (M.Init.)

DATE OF BIRTH: \_\_\_\_\_ GRADE: \_\_\_\_\_

### SCHOOL LAST ATTENDED:

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

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

This student has been enrolled at the school listed below. Please send the records of the above student to:

☐ Rogers City Elementary School

Principal's Office

532 W. Erie Avenue

Rogers City, MI 49779



\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CURRENT SCHOOL WITHDRAWAL DATE: \_\_\_\_\_

DATE ENTERING NEW SCHOOL: \_\_\_\_\_

Please include Cumulative Records, Health and Immunization Records, Birth Certificate, Test Scores, Psychological, Psychiatric and/or Emotional Evaluation, etc. These will be for the professional use of authorized Rogers City Area School District personnel only. Any further information you can provide to help in proper placement of the student will be appreciated. Thank you for your prompt cooperation.

**MICHIGAN SCHOOLS**  
**Please fax student UIC #**

UIC# \_\_\_\_\_

I am the parent or guardian of the above student and give consent for such information to be sent. I am aware of my right to inspect and obtain copies of any or all records, files and data.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Parent or Legal Guardian)

FEDERAL STATUTE ENTITLED: Privacy Right of Parents and Students

Schools may send a student's educational record to officials of other schools or school systems in which the student seeks or intends to enroll, upon condition that the student's parent(s) or guardian(s) be notified of the transfer, receive a copy of the record if desired and have the opportunity to challenge the content of the record.

# Rogers City Area Schools

## Application for Schools of Choice

### School Year 2022-2023

Student's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Grade level (entering): \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Home phone: \_\_\_\_\_  
 Parent's name: \_\_\_\_\_ Work phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ P.O. Box Number: \_\_\_\_\_

Other school age children in household:

Name _____	Grade _____
Name _____	Grade _____
Name _____	Grade _____

School district of residence: \_\_\_\_\_

School currently attending: \_\_\_\_\_

Reason for request: \_\_\_\_\_

Special Education Services required? yes      no	If yes, please explain
Has the student ever been expelled from school for any reason? yes      no	If yes, how long & please explain reason for expulsion
Has the student ever been suspended from school for any reason during the past two (2) years? yes      no	If yes, please explain
Are all immunizations current? yes      no	If no, please explain
Does student have a criminal record? yes      no	If yes, state offense: _____ Name of county/court: _____ Sentence: _____
Is student currently under court jurisdiction? Yes, on probation. How long? _____	_____ No, not currently on probation

By signing below I agree to hold harmless Rogers City Area Schools district, their employees and the Board of Education members for any decision in the selection process, potential or actual participation as a Section 105 Schools of Choice student relative to academic achievement, co-curricular participation, student discipline related to behavior and all other aspects of participation as a member of a student body.

It is further understood that transportation for non-resident students will be provided by the parent/legal guardian. I also consent to have all student records information (including academic and behavioral records) released to Rogers City Area Schools from the school district previously attended.

I understand that the student may be tested in order to determine proper grade level. I understand that, due to high academic standards of Rogers City Area Schools, some academic credits may not transfer from my student's home district. I understand that, if more students apply for a grade/program than those available, the district will hold a random drawing to determine those students accepted. Finally, I understand that any misrepresentation as part of the application process may result in the dismissal of the student.

Parent or legal guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Student signature, if legal age \_\_\_\_\_ Date \_\_\_\_\_

#### Central Office use ONLY

Date application received: \_\_\_\_\_  
 \*Was student a non-resident student of RCAS last year? \_\_\_\_\_ yes      no  
 \*Does applicant have a sibling already attending RCAS? \_\_\_\_\_ yes      no  
 Application approved \_\_\_\_\_  
 Application denied (reason/comment) \_\_\_\_\_

Superintendent \_\_\_\_\_ Date \_\_\_\_\_