ELKTON-PIGEON-BAY PORT LAKER SCHOOLS
CA-60 REGISTRATION/ENROLLMENT

OFFICE DOCUMENTATION

FIRST DATE OF ATTENDANCE

BIRTHDATE
- ☐ BIRTH CERTIFICATE
- ☐ HOSPITAL RECORDS
- ☐ OTHER DOCUMENTATION

IMMUNIZATION
- ☐ COPY

SCHOOL OF CHOICE
- ☐ YES ☐ NO

DISTRICT OF RESIDENCE

Name of District

RESIDENCY STATEMENT
- ☐ YES ☐ NO

DUPLICATE MAIL

PARENT:

ADDRESS:

BUS NEEDED
- ☐ YES ☐ NO

BUS #

GUARDIAN
- ☐ YES ☐ NO

HOMEROOM/TEACHER

LOCKER #

MEALTIME ID:

STUDENT ID:

UIC #

VERIFIED BY:

TODAY'S DATE _____ SCHOOL _____

STUDENT _____ GRADE _____
Last *First* *Middle*

BIRTHDATE _____ ☐ MALE ☐ FEMALE

PHONE # _____ CELL PHONE # _____

ADDRESS _____ PO BOX # _____

_____ PLACE OF BIRTH _____
City *Zipcode*

Has your child ever attended Elkton-Pigeon-Bay Port Laker Schools? ☐ Yes ☐ No

Has this student ever received special education services or attended special education classes? ☐ Yes ☐ No

Has this student ever been suspended or expelled from any school at any location for any reason? ☐ Yes ☐ No

Student's Predominant Ethnic Background: New State and Federal regulations require the collection of racial/ethnic data. The following questions allow us to comply with these regulations.

ETHNICITY (choose one):
- ☐ Hispanic or Latino
- ☐ NOT Hispanic or Latino

RACE (choose one or more, regardless of Ethnicity):
- ☐ American indian or Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African American
- ☐ White

Michigan welcomes families of all language backgrounds. Speaking more than one language is a valuable asset! Please answer the two questions below. If your response to either question is a language other than English, the school district will give an assessment to see if your student may benefit from English language support.

What language is used most at home? _____

What language is used most by the student? _____

OTHER CHILDREN IN FAMILY

Name		Date of Birth	
Name		Date of Birth	
Name		Date of Birth	
Name		Date of Birth	
Name		Date of Birth	
Name		Date of Birth	

FAMILY DATA	***MOTHER***	***FATHER***
Name		
Country/State of Birth		
Language in Home		
Educational Status	HS 9 10 11 12 College 1 2 3 4 +	HS 9 10 11 12 College 1 2 3 4 +
Occupation		
Marital Status		
Step Parent		
Guardian		
Child Resides With		

PARENT SIGNATURE _____ _____

GUARDIAN SIGNATURE _____ Requires Documentation

August 1, 2026

Laker Student and Parent (s):

Please review the 2026-2027 Parent/Student Handbook that can be found on the Laker Schools website: www.lakerschools.org (elementary tab/parent tab/handbook). If you do not have internet access and would like a paper copy sent home, please let the office know (989) 453-4600, option 2.

- Both students and parents must sign this form before the student is permitted access to district technology.

Elkton-Pigeon-Bay Port Laker Elementary School
STUDENT/PARENT ACKNOWLEDGEMENT FORM

STUDENT SECTION

STUDENT NAME _____

GRADE _____ **TEACHER** _____

By signing this, I acknowledge that I have read the Elkton-Pigeon-Bay Port Laker School's Student Handbook, including the Technology Acceptable Use Policy/Agreement, Cell Phone Policy, and Dress Code Policy. I agree to follow the rules contained in these policies and understand that if I violate the rules disciplinary measures will be followed.

Student Signature: _____ **Date:** _____

PARENT SECTION

By signing this, I acknowledge that I have read the Elkton-Pigeon-Bay Port LAKER School's Student Handbook, including the Acceptable Use Policy/Agreement, Cell Phone Policy, and Dress Code Policy and have reviewed the policies with my son/daughter. I will emphasize the importance of personal responsibility when using the technologies and will reinforce the importance of following the rules for personal safety.

Tasteful pictures of Laker students may be taken at school activities. This may include but is not limited to: newsletters, class projects, district website and newspaper articles.

- **As a parent/guardian, I have the option to Opt-out & not allow my student to participate in Laker pictures at school activities. I must provide a written statement with signature and date to the Elementary Office.**

Parent/GuardianSignature: _____ **Date:** _____

ELKTON-PIGEON-BAY PORT LAKER SCHOOLS

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 students 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 **EPBP LAKER SCHOOLS** *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 LAST: _____ **FIRST:** _____ **Date of Birth:** _____

Signature of Parent/Guardian or Eligible Student: _____ Date: _____

Printed Parent/Guardian Name: _____

ELKTON-PIGEON-BAY PORT LAKER SCHOOLS

6136 Pigeon Road ♦ Pigeon, MI 48755

REQUEST FOR EDUCATIONAL RECORDS

I hereby request:

Name of Previous School: _____

City, State, Zip _____

FAX #: _____

To release and send the records of:

Student Name: _____

Date of Birth: _____ Grade Entering: _____

Specific Information Needed:

Educational File (CA-60)
Transcript of Grades
Health Records
Latest MET/Psychological Report
Latest IEPC
UIC Code

To whom records are to be sent:

ELEMENTARY

Laker Elementary School
Dee Esch
6436 Pigeon Road
Pigeon, MI 48755

Phone # 989-453-4631
FAX # 989-453-4629

I authorize the release of all records for the above named student to the Laker Schools.

Parent/Guardian Signature: _____ Date: _____

Informed Consent for Counseling Services

Student Name: _____ School District _____

Student Grade: _____ Student DOB: _____

Introduction

Huron Intermediate School District has received funding to expand mental health services to students not receiving special education services. To achieve this goal, parents/ guardians or school staff may refer students for counseling (individual and/or group), or students may request counseling. The focus of the counseling program is to promote more effective education and socialization within the school community. There is no cost for counseling services that are provided through this program during the school year.

Provision of Services

It is a generally accepted policy to obtain the parent/ guardian's permission for counseling when it is for more than crisis intervention. Services may be individual, group, short or long term, depending on the needs of your child. These services are not intended as a substitute for diagnosis or treatment for any mental health disorder. Referrals to outside agencies will be provided to the parent when appropriate.

Confidentiality

In order to build trust with the child, the counselor/therapist will keep information confidential, with some possible exceptions. Because these services are provided to minor children in the school setting, the provider may share information (on a need to know basis) with parents/guardians, the child's teacher, and/or administrators or school personnel who work with the child so that we may better assist the child as a team. The provider is also required by law to share information with parents or others in the event the child is in danger of harm to self or others. The Michigan Child Protection Law requires the provider to report suspicions of child abuse or neglect to Children's Protective Services. The provider will make the child aware of these limits to confidentiality and will inform the child when sharing information with others. If you would like the counselor/therapist to share information with a third party, such as a community counselor, psychiatrist, social services worker, or pediatrician, the parent/legal guardian will need to sign an additional release of information form.

I understand that the therapist will keep information confidential with the following exceptions:

- If they are being harmed
- If they are currently harming or planning on harming themselves or others
- If they know of anyone who might be doing harm to themselves or others
- If the counselor/therapist suspects child abuse or neglect

The student will be informed when that confidentiality has to be broken.

Parent/Guardian Consent

If a signed consent form is on file, your child will be able to receive the services described above. This could include counseling services related to anger/stress management, bullying, depression, friendship skills, etc. If you have questions about these services, please contact Geralyn Kolar at Huron ISD at (989)269-3464.

Check yes if you would like your child to receive these services if social/emotional health counseling services are needed.

☐YES ☐NO

I have reviewed the above information and hereby give my consent for my child to participate in counseling services and agree to abide by the guidelines of confidentiality. I also understand that I can revoke my consent at any time. By signing this consent form, I certify that I am the legal guardian and legal custodian of the student listed above.

_____ _____

Parent/Guardian Signature (or age of majority student) Date

HISD USE ONLY

This consent was revoked on _____

_____ ____/____/____

Signature Date

School Office: Please return this to the Huron ISD School Social Worker.

It is the policy of the Huron Intermediate School District to not discriminate on the basis of race, color, religion, national origin or ancestry, sex, gender, disability, age, height, weight, marital status, genetic information, or any other legally-protected characteristic, in its programs, activities, or employment. Inquiries regarding this nondiscrimination policy should be directed to Superintendent, Huron Intermediate School District, 1299 S. Thomas Rd., Suite 1, Bad Axe, MI 48413; (989)269-6406.

LAKER ELEMENTARY SCHOOL

ALLERGIES, MEDICATIONS, & AUTHORIZATION FORM

SCHOOL YEAR: _____

STUDENT LAST _____ **FIRST** _____ **GRADE** **TEACHER** _____

ANY KNOWN ALLERGIES _____

_____

_____

PLEASE LIST ANY MEDICATIONS TAKEN BY THE CHILD

_____

_____

_____

PLEASE NOTE ANY SPECIAL FACTORS (braces, wheelchairs, seizures, previous surgeries, injuries, asthma, etc

_____

_____

_____

PLEASE INITIAL IN EACH BOX AND SIGN/DATE AT THE BOTTOM

_____ I understand that my child's immunizations must be kept up-to-date or I must sign a waiver from the Health Department otherwise my child will not be allowed to attend school.

_____ I give permission to the school/personnel to transport my child for field trips.

In the event this child should need emergency medical treatment, I authorize school personnel to provide necessary first aid. In case of accident or serious illness, I authorize school personnel, or other emergency personnel, to transport this child to the emergency room of the nearest hospital. I further authorize the hospital, and its medical staff, to provide emergency treatment deemed necessary by them for the well-being of this child.
Act 116 of P.A. 1973

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

PARENT & ATHLETE CONCUSSION INFORMATION SHEET



HEADS UP CONCUSSION

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 bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth.
Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports one or more symptoms of concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury. The athlete should only return to play with permission from a health care professional experienced in evaluating for concussion.

DID YOU KNOW?

- Most concussions occur without loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

SYMPTOMS REPORTED BY ATHLETE:

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

SIGNS OBSERVED BY COACHING STAFF:

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

MDHHS
Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

"IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON"

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

WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

1. **If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion says s/he is symptom-free and it's OK to return to play.**
2. **Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, and playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.**
3. **Remember: Concussions affect people differently. While most athletes 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.**

WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. They can even be fatal.

STUDENT-ATHLETE LAST NAME

STUDENT-ATHLETE FIRST NAME

STUDENT-ATHLETE NAME SIGNED

DATE

GRADE/TEACHER

PARENT OR GUARDIAN NAME PRINTED

PARENT OR GUARDIAN NAME SIGNED

DATE

Content Source: CDC's Heads Up Program. Created through a grant to the CDC Foundation from the National Operating Committee on Standards for Athletic Equipment (NOCSAE).

HEADS UP

JOIN THE CONVERSATION www.facebook.com/CDCHeadsUp

TO LEARN MORE GO TO >> WWW.CDC.GOV/CONCUSSION

LAKER ELEMENTARY SCHOOL

EMERGENCY INFORMATION FORM

SCHOOL YEAR: _____

STUDENT NAME _____ **GRADE/TEACHER** _____

BIRTHDATE _____ **BUS NUMBER** _____

ADDRESS _____ **BUS DRIVER** _____

PO BOX _____ **TOWN STOP** _____

CITY/STATE/ZIP _____ **EMAIL** _____

PARENT NAME _____ **PARENT NAME** _____

CELL PHONE _____ **CELL PHONE** _____

ADDRESS _____ **ADDRESS** _____

If different from child's **If different from child's**

CITY/STATE/ZIP _____ **CITY/STATE/ZIP** _____

EMPLOYER _____ **EMPLOYER** _____

CITY _____ **CITY** _____

WORK PHONE _____ **WORK PHONE** _____

In case of emergency the school will first notify the parent/guardians. If they are not available, the school with then Contact one of the persons listed below. These people will be authorized to pick up or drop off your child.

NAME _____ **RELATIONSHIP** _____

CELL PHONE _____ **HOME PHONE** _____ **WORK PHONE** _____

NAME _____ **RELATIONSHIP** _____

CELL PHONE _____ **HOME PHONE** _____ **WORK PHONE** _____

CHILDCARE PROVIDER'S NAME _____

CELL PHONE _____ **HOME PHONE** _____

NAMES OF PERSONS (Other than emergency contact, childcare provider and parents) that child may be released to:

_____ _____ _____

In the event this child should need emergency medical treatment, I authorize school personnel to provide necessary first aid. In case of accident or serious illness, I authorize school personnel, or other emergency personnel, to transport this child to the emergency room of the nearest hospital. I further authorize the hospital, and its medical staff, to provide emergency treatment deemed necessary by them for the well-being of this child. Act 116 of P.A. 1973

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

LAKER SCHOOLS TECHNOLOGY

iPad/Chromebook Parent Agreement

STUDENT NAME _____ GRADE/TEACHER _____

I have read and understand the following:

I am responsible for replacement of my child's device (iPad/Chromebook/Case/Charger) in the event that it gets broken or stolen. The cost for each is as follows:

iPads (DK-4th Grade):

- Cracked iPad screen (iPad still displays video) - $30.00
- Broken iPad (iPad does not display video) - $300.00
- iPad charger replacement - $20.00
- iPad case replacement - $100.00 (except DK, $20.00)
- Headphone Replacement - $5.00

Chromebooks (5th Grade):

- Cracked Chromebook screen (Chromebook is still functional) - $25.00
- Broken Chromebook - $265.00
- Chromebook charger replacement - $15.00
- Chromebook keyboard replacement - $50.00
- Outer case damage - $25.00
- Hot Spot replacement - $85.00

☐ **Please check this box if you DO NOT want your child to bring their technology devices home with them.**

☐ **Please check this box if your student would not otherwise have their own device for homework**

☐ **Please check this box if you do not have home internet or if your home internet is insufficient for completing homework that requires your iPad or Chromebook.**

HAVING COMPLETED A REVIEW OF THE ABOVE, PLEASE COMPLETE AND SIGN THE FOLLOWING:

I approve for my child to take their assigned iPad/Chromebook home from school. I understand that by doing so, I am responsible for monitoring its use, monitoring safe internet usage at home, as discussed in the Laker Schools Technology Rules and in the Acceptable Use policies.

Laker Schools
ACCEPTABLE USE AGREEMENT

Advances in telecommunications and other related technologies have fundamentally altered the ways in which information is accessed, communicated, and transferred in society. Such changes are driving the need for educators to adapt their means and methods of instruction, and the way they approach student learning, to harness and utilize the vast, diverse, and unique resourced available on the Internet. The Board of Education is pleased to provide Internet services and encourages students and staff to utilize the Internet in order to promote educational excellence in our schools by providing them with the opportunity to develop the resource sharing, innovation, and communication skills and tools which will be essential to life and work in the 21st century. The instructional use of the Internet will be guided by the Board's policy.

The District's Internet system has not been established as a public access service or a public forum. The Board has the right to place restrictions on its use to assure that use of the District's Internet system is in accordance with its limited educational purpose. Student use of the District's computers, network, and Internet services (Network) will be governed by this policy and the related administrative guidelines, and the Student Code of Conduct. The due process rights of all users will be respected in the event there is a suspicion of inappropriate use of the Network. Users have no right or expectation to privacy when using the Network including, but not limited to, privacy in the content of their personal files, e-mails, and records of their online activity while on the Network. The user will be required to agree to the Laker Schools Acceptable Use Policy Agreement prior to being able to connect to the Internet through the Laker network or utilize a District owned device with Internet access.

The Internet is a global information and communication network that provides students and staff with access to up-to-date, highly relevant information that will enhance their learning and the education process. Further, the Internet provides students and staff with the opportunity to communicate with other people from throughout the world. Access to such an incredible quantity of information and resources brings with it, however, certain unique challenges and responsibilities.

- I acknowledge that I am responsible for my actions on my device and for following the specific rules established for the use of the hardware, software, labs, and networks throughout the district. I understand that failure to do so could result in a loss of technological privileges.
- I will not share my password or account with anyone and will have full responsibility for the use of my account. I will not use another's account or represent myself as someone else.
- I will not engage in illegal activities on the network, computer and technological devices (i.e. plagiarism, bullying, harassment, tampering with hardware, software or documents; vandalism; unauthorized entry or destruction of files; or deliberate introduction of computer viruses).
- I will obey procedural safeguards to maintain the performance of the network, computer and technological devices. This includes uninstalling/tampering with apps installed by the school.
- I will respect the rights of others, use appropriate language and avoid offensive or inflammatory material. I will bring incidents of offensive or inflammatory material directed to myself or others to the attention of a Laker staff member.
- I will not share, make, or post online personally identifying information about any members of the Laker community without permission (addresses, phone numbers, email addresses, photos, videos, etc.)
- I will access only those resources that are appropriate for school and those District network resources for which I have specific authorization.
- I will obey copyright laws and license agreements. Text material, music, software, and other media are protected by law.
- I will not install software on the network, computer or technological devices without permission of the system administrators.
- I understand that administrators and teachers may access my files anytime and without advanced notice.
- Staff and students who are issued school owned tablets are responsible for their care. Charges related to repair and replacement caused by abuse, misuse, negligence or loss as determined by school administration will be the responsibility of the staff member or student.
- I understand that I will file a police report for any school device that is assigned to my child that is stolen or is missing.

Violation of this Acceptable Use Agreement may result in:

- Loss of school provided technology and network privileges
- Laker sanctions as prescribed by the student handbook
- Monetary reimbursement to Laker Schools or other appropriate sources – Prosecution under applicable civil or criminal laws.

Laker School reserves the right to addend or amend the policy at any time.

As a student at Lakers, I acknowledge that I have read through and agree to the Laker Acceptable Use Agreement.

STUDENT Signature _____ **Date** _____

I acknowledge that my son/daughter and I have read through and agree to the Laker Acceptable Use Agreement. I will instruct my child regarding the importance of following all the guidelines included in this agreement.

PARENT Signature _____ **Date** _____

ELKTON-PIGEON-BAY PORT LAKER SCHOOLS
STUDENT RESIDENCY

By completing this questionnaire, you help the district comply with the McKinney-Vento Act, Title X, Part C of the No Child Left Behind Act. Your truthful and accurate answers help the district identify services that the student may be eligible to receive.

School LAKER ELEMENTARY

Student's NAME _____ Male _____ Female _____

Date of Birth (month/day/year _____ Age _____

Parent(s) / Legal Guardian(s) Name _____

Address _____ City/State/Zip _____

Telephone # _____ Cell Phone # _____

Michigan welcomes families of all language backgrounds. Speaking more than one language is a valuable asset! Please answer the two questions above. If your response to either question is a language other than English, the school district will give an assessment to see if your student may benefit from English language support.

Parent/Legal Guardian Signature _____ Date _____

1 Where is the student living now? (please check <u>one</u> box)

- ___ In a shelter
- ___ In a car
- ___ Temporary housing
- ___ None of the above
- ___ In a motel or hotel
- ___ In a trailer park or campsite
- ___ With more than one family in a house or apartment
- ___ With friends or family members (other than parent or guardian)

If you checked the box "none of the above" the remainder of this form does not need to be completed.

2 Does the living arrangement checked in question 1 result from a loss of housing or economic hardship?

___ Yes ___ No ___ Unsure

3 The student lives with:

- ___ 1 Parent
- ___ 2 Parents
- ___ 1 parent & another adult
- ___ A relative, friend(s), or other adult(s)
- ___ Alone with no adults
- ___ An adult who is not the parent or the legal guardian

FOR SCHOOL USE ONLY

All buildings must keep the original forms separately from the Student Permanent Record for audit purposes during the year.

- ___ Student not covered by McKinney-Vento Act
- ___ Student covered by McKinney-Vento Act
- ___ Follow-up required

School Contact Person: **REBECCA KROHN** Phone: 989-453-4600 option 2

Contact Person Signature _____

Scheurer Wellness Clinic

Laker Elementary School
Student Health History

To be completed by parent / guardian

Student Last Name:		First Name:			Middle Initial:		
Date of Birth:	Age:	Male	Female	Grade:		Teacher:	
Street/Mailing Address:							
City, Zip Code:							
Parent/Guardian Name:		Relationship to Student:					
Primary Phone #	Cell #		Work #				
Parent/Guardian Name:		Relationship to Student:					
Primary Phone #	Cell #		Work #				
Name of Emergency Contact:	Relationship to Student:		Phone #:				
Pharmacy Preference:	Pharmacy Location:		Pharmacy Phone #:				
Name of Student's Family Dr./NP/PA:							
Date of Student's Last Well Child Exam:							

Please **X** the YES column if any of these conditions apply to the student or mark here **NONE:**

CONDITION	YES	CONDITION	YES	CONDITION	YES
Asthma		Epilepsy		Pneumonia	
ADD/ADHD		Fainting		Seizures	
Anemia		Frequent Urination		Shortness of Breath	
Backaches		Heart Problems		Skin Disorder	
Bipolar Disorder		Headaches/Migraines		Sore Throats	
Bladder Problems		High Blood Pressure		Substance Abuse	
Diabetes		Joint Problems		Vision Problems	
Depression		Kidney Disease		**Other Conditions:**	
Eating Disorder		Nosebleeds			
Eczema/rashes		Pounding of Heart			

Indicate any allergies your child has:

Food Allergies:	Medication Allergies:	Environmental Allergies:	Other Allergies:

Does the student carry an **Epi-Pen**?	Where is **Epi-Pen** stored:	Has student used the **Epi-Pen** in the past?

Please indicate surgeries or hospitalizations the student has had:

Surgeries:	**Hospitalizations:**

Please list any other concerns you have regarding your child:

Daily Medications: List any medications the student takes regularly.

	Name of Medication	**Dosage**	**Frequency**
1.			
2.			
3.			
4.			
5.			

Would you like the clinic to administer any of your child's daily medications?

	Yes – Please complete separate Daily Medication Administration form.
	No
	N/A

The Scheurer Wellness Clinic stocks the following:

Benadryl	Antibiotic Cream	Albuterol (nebulizer treatment)	Claritin (24 hr Allergy)
Hydrocortisone Cream	Guaifenesin (cough expectorant)	Motrin (Ibuprofen)	Silvadene Cream
Thera Tears (eye lubricant)	Tylenol (Acetaminophen)	Anbesol	Antacid
Icy Hot	Cough Drops		

CHECK ONE:

☐ **I give permission** for my child to take the above medications if indicated per standard clinic treatments.

☐ **I give permission** to use above medications ***except*** _____

☐ Scheurer Wellness Clinic **DOES NOT have my permission** to give any medications to my child.

SIGN:

Parent/Guardian Signature _____

Date _____

Scheurer Wellness Clinic
Laker Elementary School
Parent/Guardian Consent

I give consent for my child to receive services at the Scheurer Wellness Clinic. By signing this consent I certify that I am the legal guardian and legal custodian of the student listed below. I understand I may withdraw my consent at any time with written notice and I understand it is my responsibility to be sure the Scheurer Wellness Clinic has received my withdrawal of consent.

I further authorize the Scheurer Wellness Clinic to release information regarding treatment to other medical or mental health providers when needed for coordination of care. I further authorize both the Scheurer Wellness Clinic and my child's primary care provider to exchange health care information for the purpose of continuity and coordination of care. I give permission to the Scheurer Wellness Clinic to obtain a copy of my child's immunization record from the Michigan Care Improvement Registry (MCIR), the school office or the local health department and record updates as needed.

I understand that as an entity of Scheurer Healthcare Network, the Scheurer Wellness Clinic participates in and recognizes the rules of the Health Information Portability and Accountability Act (HIPAA). In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or communications by alternative means such as to a cell phone instead of the home phone.

I understand that if anyone involved in my child's care has an exposure to any of my child's blood or other body fluids, a blood or tissue test may be performed on my child without consent to detect the presence of human immunodeficiency virus (HIV) or other communicable diseases.

The Scheurer Wellness Clinic may confirm, for school attendance purposes only, the dates and times that a student was in the clinic. Protected Health Information will not be communicated to school administration.

This consent will be considered active for the entire school year, unless I withdraw my consent in writing. I understand I may withdraw my consent for service upon written notice to the Scheurer Wellness Clinic at any time.

STUDENT LAST: _____ FIRST _____ GRADE/TEACHER _____

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

Parental Consent is not required for crisis intervention or emergency care.
Emergency care/crisis intervention will be provided, with parental notification to follow.

HURON ISD PUBLIC SCHOOLS

SCHOOLS OF CHOICE APPLICATION

This Schools of Choice Application must accompany the Student Enrollment Form.

STUDENT'S LEGAL NAME:_____ **DATE OF BIRTH:**_____

FIRST NAME *MIDDLE INITIAL* *LAST NAME*

GRADE APPLYING FOR: _____

APPLICATION

Complete one application for each student. Kindergarten – 12th grade students in Huron ISD and bordering ISDs may apply to attend other participating public school districts in these ISDs. This application form must be completed and sent to the school district at the following address: EPBP Laker Schools, 6136 Pigeon Road, Pigeon, MI 48755, Phone Number: (989)453-4600. Applicants will be notified of approval or disapproval.

Admission may only be available to a student applicant for a specific grade, school, and/or special program which has been specifically identified as open for enrollment by the Board of Education. Admission is subject to the terms and conditions of the policies, rules, and regulations of the Board of Education, its administrators, this Application, and applicable Michigan Law.

SUSPENDED / EXPELLED STUDENTS

Our School District may refuse to enroll a nonresident applicant if:

- The applicant is, or has been within the preceding 2 years, suspended from another school.
- The applicant has at any time been expelled from another school
- The applicant has at any time been convicted of a felony

SECTION 105C SPECIAL NEEDS STUDENTS

Applicants under section 105C (crossing ISD boundaries) with special needs will not be approved until the resident district enters into a cooperative agreement as mandated.

TRANSPORTATION

The School District is not required to provide transportation for a nonresident pupil who becomes enrolled through the Schools of Choice program or for a resident pupil enrolled in another school district through a Schools of Choice program (except as may be required by federal law).

INFORMED CONSENT

I understand that the Student Applicant must meet the same criteria, other than residence, which an applicant who is a resident of the school district must meet for enrollment in a grade, specialized, magnet or intra-district choice school or special program to which admission is requested for this Student Applicant. I state and declare that all of the information provided in the Application is accurate and true.

I understand that if any of the above information which I have provided is inaccurate, a misrepresentation or otherwise incomplete in any way, that this Application for admission to the EPBP Laker School District may be rejected. I also understand that submission of the Application to the EPBP Laker School District does NOT guarantee or assure that admission and enrollment will be granted. I understand that I may be required to complete an Authorization To Release Information to the EPBP Laker School District as part of enrollment.

_____ _____

Signature of Parent/Guardian Date

RECEIVING INFORMATION *(to be completed by a school district official)*

Date Application Received: _____ **Signature of School Official:** _____

APPLICATION STATUS: ☐ **Approved** ☐ **Disapproved**

_____ _____

Signature of School Official Date

Huron County

Student Enrollment Application

Directions for Applicants: Please complete all sections. **SCHOOL DISTRICT:** EPBP LAKER SCHOOLS

STUDENT DEMOGRAPHIC INFORMATION

STUDENT'S LEGAL NAME: _____ **CURRENT GRADE:** ____
FIRST NAME MIDDLE INITIAL LAST NAME

DATE OF BIRTH: _____ **PLACE OF BIRTH:** _____ **GENDER: MALE** ☐ **FEMALE** ☐

HOME PHONE: _____ **CELL PHONE:** _____ **STUDENT'S CELL #:** _____

ADDRESS: _____
HOUSE # STREET/ROAD APT/UNIT # CITY ZIP CODE

SCHOOL STUDENT IS CURRENTLY ATTENDING (OR LAST ATTENDED): _____

HOME LANGUAGE: Is your child's native tongue other than English? ☐ Yes ☐ No If yes, what language?_____
Is the primary language used in your child's home or environment a language other than English? ☐ Yes ☐ No
If yes, what language?_____ Immigration Date, if not born in U.S.: _____

ETHNICITY: Is this student Hispanic/Latino? (Choose only one)
- ☐ No, not Hispanic/Latino
- ☐ Yes, Hispanic/Latino – (A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race.)

RACE: (use percentages to rank ethnic groups in order)
The question above is about ethnicity, not race. No matter what you selected, please continue to answer the following by marking one or more boxes to indicate what you consider your student's race to be.
- ☐ American Indian/Alaska Native
- ☐ Asian American
- ☐ Native Hawaiian/Pacific Islander
- ☐ Black/African American
- ☐ White

RESIDENCY INFORMATION

RESIDENT DISTRICT: _____ **COUNTY OF RESIDENCE**: _____
*If student is not a resident of the district, please complete a Schools of Choice Application.

Where is the student living now? (Please check one)
- ☐ in a one-family dwelling
- ☐ with more than one family in a house or apartment
- ☐ with friends/family members (other than parent/guardian)
- ☐ in a car
- ☐ in a trailer park or campsite
- ☐ in a shelter
- ☐ in a motel or hotel
- ☐ awaiting foster care placement
- ☐ Other – please explain: _____

**Please note: If you are living in any of the above situations, you may qualify for McKinney-Vento Services.*

Does living arrangement checked above result from loss of housing or economic hardship? ☐ Yes ☐ No ☐ Unsure

The student lives with
- ☐ 1 parent
- ☐ 2 parents
- ☐ 1 parent & another adult
- ☐ a relative, friend(s), or other adult(s)
- ☐ alone with no adults
- ☐ an adult who is not the parent or the legal guardian

With whom does child reside (names and relationship): _____

SPECIAL EDUCATION INFORMATION

Is this student eligible for special education? ☐ Yes ☐ No
If yes, please check the programs/services this student has received:
- ☐ Special Education Classroom
- ☐ Occupational Therapy
- ☐ Teacher Consultant Services
- ☐ Physical Therapy
- ☐ Speech and Language Therapy
- ☐ School Social Work Services

SECTION 504 INFORMATION

Does student have a disability requiring a Section 504 Plan? ☐ Yes ☐ No

SUSPENSION/EXPULSION INFORMATION

SUSPENSION: Has this student been suspended from any school at any location for any reason at any time during the preceding two years? ☐ Yes ☐ No

If yes, please complete the following information regarding the suspension of the student:

Name of school district where student was suspended: _____

Grade and level (elementary/middle/high) of school building where suspension occurred: _____

Name of building administrator involved with the suspension: _____

Length and date(s) of suspension: _____

Specific conduct for which student was suspended: _____

_____

If the student had more than one suspension, please attach additional sheets to respond to the above questions for each incident.

EXPULSION: Has this student ever been expelled from school? ☐ Yes ☐ No

If yes, please complete the following information regarding the expulsion of the student:

Name of school district where student was expelled: _____

Grade and level (elementary/middle/high) of school building where expulsion occurred: _____

Name of building administrator involved with the suspension: _____

Length and date(s) of expulsion: _____

Specific conduct for which student was expelled: _____

_____

If the student had more than one expulsion, please attach additional sheets to respond to the above questions for each incident.

PARENT/GUARDIAN INFORMATION

MOTHER/LEGAL GUARDIAN'S NAME: _____

RELATIONSHIP TO STUDENT: ☐ Father ☐ Mother ☐ Step-parent ☐ Guardian ☐ Other *(please describe; attach relevant documents)*

ADDRESS (street, city, and zip code, include P.O. Box, if applicable)**:** _____

HOME PHONE: _____ **CELL PHONE:** _____

EMAIL ADDRESS: _____

EMPLOYER: _____ **WORK PHONE:** _____

FATHER/LEGAL GUARDIAN'S NAME: _____

RELATIONSHIP TO STUDENT: ☐ Father ☐ Mother ☐ Step-parent ☐ Guardian ☐ Other *(please describe; attach relevant documents)*

ADDRESS (street, city, and zip code, include P.O. Box, if applicable)**:** _____

HOME PHONE: _____ **CELL PHONE:** _____

EMAIL ADDRESS: _____

EMPLOYER: _____ **WORK PHONE:** _____

OTHER CHILDREN IN HOUSEHOLD:

NAME: _____ **DATE OF BIRTH:** _____ **GENDER: MALE** ☐ **FEMALE** ☐

NAME: _____ **DATE OF BIRTH:** _____ **GENDER: MALE** ☐ **FEMALE** ☐

NAME: _____ **DATE OF BIRTH:** _____ **GENDER: MALE** ☐ **FEMALE** ☐

NAME: _____ **DATE OF BIRTH:** _____ **GENDER: MALE** ☐ **FEMALE** ☐

NAME: _____ **DATE OF BIRTH:** _____ **GENDER: MALE** ☐ **FEMALE** ☐

SIGNATURE OF APPLICANT

GRADE LEVEL REQUESTED (example: 5th, 8th, 12th): _____

_____ **DATE:** _____

APPLICANT'S SIGNATURE (PARENT, GUARDIAN, OR STUDENT, IF OVER 18)