NEW STUDENT ACCEPTANCE PACKET

School Year:_____

A completed packet is required for each child. To confirm acceptance of your child's seat, complete and sign all forms and return by **EMAIL** to **info@ompschool.org**
or **MAIL** to OMPS 2699 Island View Road, Traverse City, MI 49686

STUDENT INFORMATON

_____ _____ _____
FIRST NAME **MIDDLE NAME** **LAST NAME**

Date of Birth_____Gender_____ Grade in new school year _____

How did you hear about us?_____

Thank you for choosing Old Mission Peninsula School and allowing us the opportunity to serve your family.
To confirm enrollment in OMPS, we must receive the following documentation for your child.

Required for ALL STUDENTS

- Completed Acceptance Packet forms
- **Present the office with and Official Birth Certificate for verification (not a copy)**
- Copy of child's immunization records or exemption waiver - please see attached Michigan Department of Health and Human Services information sheet entitled "Vaccines Required for School Entry in Michigan"
- Medical Authorization Forms: If you answer "Yes" to any of the questions under MEDICAL ALERTS – ADDITIONAL MEDICAL AUTHORIZATION, please contact us and we will provide the required Medical Authorization Forms for completion
- ***If applicable***: Legal Custody Papers (required if a non-custodial parent is legally prohibited from contact)

Required for STUDENTS ENTERING KINDERGARTEN

If applicable: Kindergarten Waiver of Eligibility Requirement

- Michigan law states that if a child is not five years of age on or before September 1 of the current school year, but will turn five years of age not later than December 1 of the current school year, the parent or legal guardian may choose to enroll the child in kindergarten for the same school year. Please contact OMPS if this applies to your child.

Required for student entering GRADES 1 – 5

- Records request authorization allowing OMPS to request records from previous school
- Most recent report card/transcripts
- Most recent standardized assessment results (e.g., NWEA)
- ***If applicable***: Individual Education Plan (IEP) or other learning plan
- ***If applicable***: Behavior Intervention Plan (504)

NOTE: If the student record file received from your child's previous school is not complete, OMPS will contact you for additional information.

CHILD'S RACE/ETHNICITY INFORMATION

ETHNICITY
☐ HISPANIC/LATINO

RACE
☐ AMERICAN INDIAN/ALASKAN NATIVE
☐ ASIAN AMERICAN
☐ BLACK/AFRICAN AMERICAN
☐ HISPANIC/LATINO
☐ NATIVE HAWAIIAN
☐ WHITE

STUDENT DEMOGRAPHICS

Is the student/family living in any of the following locations/situations: ☐YES ☐NO

☐ Unsheltered (on the street)
☐ Sheltered
☐ Transitional Housing
☐ Foster Care (6-month period)
☐ Doubled-Up (with friends or relatives)
☐ Hotel/Motel
☐ Unaccompanied Youth

Is the student a migrant: ☐YES ☐NO

As the parent/guardian of _____my signature below verifies that the enrollment forms and documentation I am providing to OMPS are accurate and up to date.

_____ _____ _____
LEGAL GUARDIAN NAME **LEGAL GUARDIAN SIGNATURE** **DATE**

STUDENT RECORDS REQUEST

FOR ADMISSION FOR THE _____ SCHOOL YEAR

Student's full legal name (as written on birth certificate)

_____ _____ _____
FIRST NAME MIDDLE NAME LAST NAME

Student's date of birth (MM/DD/YY) _____ Student's current grade _____

Name and phone number of last school attended _____

Date student is scheduled to begin at OMPS (MM/DD/YY) _____

Please include all relevant records including:

- State School ID Number
- Attendance & Truancy Records
- Immunization/Medical Records
- Custody Papers – if applicable
- Official Transcripts/Report Cards/Grades
- Individualized Education Plans (IEP)
- Multifactor Evaluation (MFE)
- Behavior Intervention Plans (504)
- Pupil Personnel & Special Services
- Permanent/Cumulative Records
- Standardized Test Scores
- Academic or Disciplinary Intervention
- ESL/ELL/WIDA Reports

Please send all records to: Old Mission Peninsula School

By Mail 2699 Island View Road
Traverse City, MI 49686
or
By Email info@ompschool.org

I give permission for the release of my child's Cumulative Student Record (CA60 to OLD MISSION PENINSULA SCHOOL - MICHIGAN SCHOOL DISTRICT CODE 28900 for the purpose of enrollment in the _____school year and to aid in present and future educational decisions.

_____ _____ _____
LEGAL GUARDIAN NAME LEGAL GUARDIAN SIGNATURE DATE

Student's full legal name (as written on birth certificate)

_____ _____ _____
FIRST NAME MIDDLE NAME LAST NAME

HOME LANGUAGE SURVEY

Federal rules and regulation require that school districts be aware of students who speak or understand a language other than English. Responses to the following questions will be used to determine whether your student will be assessed for English language proficiency.

What is the student's first language?

_____

What language is spoken at home?

_____

Does the student speak and/or understand a language other than English ☐ YES ☐ NO
If yes, which language? _____

Can the student read in a language other than English? ☐ YES ☐ NO
If yes, which language? _____

Can the student write in a language other than English? ☐ YES ☐ NO
If yes, which language? _____

Has your child ever been enrolled in an English as a Second Language (ESL) program? ☐ YES ☐ NO
If yes, where and when?

_____ _____ _____
SCHOOL NAME DATES OF SERVICE # OF YEARS IN PROGRAM

If yes, did the student ever exit the ESL program? ☐ YES ☐ NO
If YES, what was the exit date? (Month/Year) _____

STUDENT EDUCATION HISTORY

Name/address of current school _____

Type of school: ☐ PUBLIC ☐ PRIVATE ☐ HOMESCHOOL ☐ PUBLIC CHARTER
☐ ONLINE ☐ DAYCARE ☐ N/A

Has your child ever been retained in any grade? ☐ YES, WHICH GRADE? _____ NO ☐
Was your child receiving Gifted and Talented Services? ☐ YES ☐ NO

Was your child receiving Special Education Services as defined by an Individualized Education Plan (IEP)?
☐ YES ☐ NO
If yes, please briefly describe below, and attach a copy

_____
(Speech, Occupational Therapy, Physical Therapy, Learning Disabled, etc.)

Does your child have a 504 Behavior Intervention Plan? ☐ Yes ☐ No
If yes, please attach a copy.

KINDERGARTEN ONLY

Has your child attended any type of Preschool Program? ☐ Yes ☐ No
If yes, please provide the name/location of the preschool _____

PARENT/GUARDIAN INFORMATION

Student's full legal name (as written on birth certificate)

FIRST NAME _____ MIDDLE NAME _____ LAST NAME _____

PRIMARY PARENT/GUARDIAN CONTACT

FIRST NAME _____ LAST NAME _____

RELATIONSHIP TO STUDENT _____ EMPLOYER _____

CELL PHONE _____ EMAIL ADDRESS _____

HOME/OTHER PHONE _____ WORK/OTHER PHONE _____

STREET ADDRESS _____ CITY, STATE ZIP _____

SECONDARY PARENT/GUARDIAN CONTACT

FIRST NAME _____ LAST NAME _____

RELATIONSHIP TO STUDENT _____ EMPLOYER _____

CELL PHONE _____ EMAIL ADDRESS _____

HOME/OTHER PHONE _____ WORK/OTHER PHONE _____

STREET ADDRESS _____ CITY, STATE ZIP _____

OPTIONAL ADDITIONAL PARENT/GUARDIAN CONTACT (STEP-PARENT, GRANDPARENT, CARETAKER, ETC.)

FIRST NAME _____ LAST NAME _____

RELATIONSHIP TO STUDENT _____ EMPLOYER _____

CELL PHONE _____ EMAIL ADDRESS _____

HOME/OTHER PHONE _____ WORK/OTHER PHONE _____

STREET ADDRESS _____ CITY, STATE ZIP _____

OPTIONAL ADDITIONAL PARENT/GUARDIAN CONTACT (STEP-PARENT, GRANDPARENT, CARETAKER, ETC.)

FIRST NAME _____ LAST NAME _____

RELATIONSHIP TO STUDENT _____ EMPLOYER _____

CELL PHONE _____ EMAIL ADDRESS _____

HOME/OTHER PHONE _____ WORK/OTHER PHONE _____

STREET ADDRESS _____ CITY, STATE ZIP _____

SPECIAL INSTRUCTIONS (CUSTODY ISSUES, DAYCARE, ETC.) _____

_____

_____

NOTE: Please feel free to attach extra pages to this packet with any additional information about your child that you feel may be important for the school to be aware of. School staff is also available to meet with you in person to discuss your child.

Student's full legal name (as written on birth certificate)

FIRST NAME ______ MIDDLE NAME ______ LAST NAME ______

EMERGENCY CONTACT INFORMATION: I understand that providing current emergency contact information is critical to the safety and well-being of my child. My signature on this packet certifies my understanding and commitment to provide updates (in writing) of any and all changes in contact information for myself, and my emergency contacts, with 24 hours of any change, to the school office and my child's classroom teacher. This information will be shared, as necessary, with teachers and administrative staff.

LOCAL EMERGENCY CONTACTS: Adults 18 years or older who may be contacted in the event of an emergency in addition to the student's primary and secondary parent/guardians who were entered on the PARENT/GUARDIAN INFORMATION section of this packet.

AUTHORIZED PICK UP: In addition to any parent/guardian/caretaker listed previously to pick your child up from school, you may authorize others to do so. Proof of identification in the form of a photo ID is required when picking up children.

EMEGENCY CONTACT ☐ **AUTHORIZED PICK UP** ☐

FIRST NAME ______ LAST NAME ______

RELATIONSHIP TO STUDENT ______ EMPLOYER ______

CELL PHONE ______ EMAIL ADDRESS ______

HOME/OTHER PHONE ______ WORK/OTHER PHONE ______

STREET ADDRESS ______ CITY, STATE ZIP ______

EMEGENCY CONTACT ☐ **AUTHORIZED PICK UP** ☐

FIRST NAME ______ LAST NAME ______

RELATIONSHIP TO STUDENT ______ EMPLOYER ______

CELL PHONE ______ EMAIL ADDRESS ______

HOME/OTHER PHONE ______ WORK/OTHER PHONE ______

STREET ADDRESS ______ CITY, STATE ZIP ______

EMEGENCY CONTACT ☐ **AUTHORIZED PICK UP** ☐

FIRST NAME ______ LAST NAME ______

RELATIONSHIP TO STUDENT ______ EMPLOYER ______

CELL PHONE ______ EMAIL ADDRESS ______

HOME/OTHER PHONE ______ WORK/OTHER PHONE ______

STREET ADDRESS ______ CITY, STATE ZIP ______

LEGAL GUARDIAN NAME ______ LEGAL GUARDIAN SIGNATURE ______ DATE ______

Student's full legal name (as written on birth certificate)

_____ _____ _____

FIRST NAME MIDDLE NAME LAST NAME

STUDENT HEALTH HISTORY Has your child ever been diagnosed with – or treated for – any of the following?

- ☐ ADD/ADHD
- ☐ Allergies/Hay Fever
- ☐ Asthma/Wheezing
- ☐ Autism
- ☐ Behavior Concerns
- ☐ Birth Defects
- ☐ Bone/Muscle/Joint Issues
- ☐ Emotional Disorder
- ☐ Bowel/Bladder Issues
- ☐ Cancer
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Depression
- ☐ Developmental Concerns
- ☐ Earaches/Ear Infections
- ☐ Meningitis/Encephalitis
- ☐ Headache/Migraine
- ☐ Hearing/Ear Disorder
- ☐ Heart Condition
- ☐ Hemophilia
- ☐ Juvenile Arthritis
- ☐ Kidney Disease
- ☐ Lead Poisoning
- ☐ Vision (glasses, contacts, other)
- ☐ Neuromuscular Disorder
- ☐ Seizure Disorder
- ☐ Sickle Cell Anemia
- ☐ Skin Conditions
- ☐ Speech Issues
- ☐ Traumatic Brain Injury
- ☐ Bleeding Disorder
- ☐ Other (list below)

Additional information about above-mentioned health conditions_____

_____

_____

Other issues not mentioned above_____

_____

_____

MEDICATIONS

Does your child take any routine medications (including those taken at home)?
If yes, please list the medications your child takes on a routine basis. ___YES ___NO

Name of Medication	Dose/Frequency/Taken For	Activity Restrictions

MEDICAL ALERTS – ADDITIONAL MEDICAL AUTHORIZATION

The purpose of the following questions is to determine if your child requires additional medical authorization forms and medications to be kept on file at the school. Please add additional information if needed.

Does your child have any allergies? ☐ Yes ☐ NO

Food _____ Seasonal/Environmental_____

Insects _____ Other _____

Drug _____

Does your child require an epinephrine autoinjector (EpiPen ☐ YES ☐ NO
to treat anaphylaxis at school? ☐ YES ☐ NO

Does your child require an asthma inhaler in school to alleviate asthmatic symptoms, or before exercise to prevent the onset of asthmatic symptoms? ☐ YES ☐ NO

Does your child require diabetes management at school? ☐ YES ☐ NO

Does your child require medication during school hours? ☐ YES ☐ NO

Will your child need to self-administer non-prescription medication in school? ☐ YES ☐ NO

Student's full legal name (as written on birth certificate)

FIRST NAME	MIDDLE NAME	LAST NAME

CONSENT FOR EMERGENCY MEDICAL TREATMENT

The following medical care providers to be called

Student's Health Care Provider #1	Health Care Provider's Phone #
Student's Health Care Provider #2	Health Care Provider's Phone #
Student's Medical Specialist	Medical Specialist's Phone #

If the administration of any treatment is deemed necessary by above named medical care providers or hospital, or if for any reason the above listed medical care providers or hospital cannot be reached, I authorize appropriate transport and medical care of my child to any appropriate medical care provider, hospital, or medical facility. This authorization does not cover major surgery unless two other licensed doctors/dentists concur to the need. Nothing in this section shall be construed to impose liability on any school official or school employee who, in good faith, attempts to comply with this section. It is understood that I will be financially responsible for all emergency care.

This Consent for Emergency Medical Treatment shall continue in full force and effect until the school is advised in writing and/or via this electronic application of any change desired by the undersigned.

LEGAL GUARDIAN NAME	LEGAL GUARDIAN SIGNATURE	DATE

REFUSAL TO CONSENT TO EMERGENCY MEDICAL TREATMENT

I do not give consent for the emergency medical treatment of my child. In the event of illness or injury requiring emergency medical treatment, I wish the school authorities:

☐ To take no action

or

☐ To take the following action:

This Refusal to Consent to Emergency Medical Treatment shall continue in full force and effect until the school is advised in writing and/or via this electronic application of any change desired by the undersigned.

LEGAL GUARDIAN NAME	LEGAL GUARDIAN SIGNATURE	DATE