BARACK OBAMA
LEADERSHIP ACADEMY

Enrollment Application Grades K-5

*Acceptance is based on a **completed** application and the availability of space for each grade.*

Date: _____ / _____ / _____ School year applying for: _____ Grade applying for: _____

Student: _____ , _____ _____
(Last Name) (First Name) (M.I.)

Address: _____
(Street Address) (City) (Zip Code) (County)

Phone: _____ Work Phone: _____

Age: _____ Date of Birth: ____ / ____ / ____ Gender: Male _____ Female _____

Ethnicity/Race: *(Check all that apply)*

African American ____ American Indian ____ Caucasian ____ Hispanic ____ Multi-racial ___ Other____

Language spoken in home: _____ Child's primary language: _____

Previous School Information:

Current School Attending: _____ Current Grade Level: _____

Location: _____ City, State & Zip Code: _____

Type of School: Public _____ Private _____ Parochial _____ Charter _____ Home school _____

Was your child suspended from school during the previous school year? Yes _____ No _____

If yes, how many times? _____ Please indicate reason(s) for the child's suspension.

_____

_____

_____

_____

Has the child been expelled from school for any reason? Yes ___ No ____ Date of expulsion _____

What school year(s) _____ Please indicate reason(s) _____

Does your child require special education services? Yes ____ No _____

If yes, please provide current IEP with this application. (No exceptions!)

Do you have children who are currently students at BOLA? Yes _____ No _____

If answered yes, please list the name and grade of the student(s) for the upcoming school year:

Name: _____ Grade: _____

Name: _____ Grade: _____

Name: _____ Grade: _____

Name: _____ Grade: _____

Office use only
Birth Certificate _____ Immunizations_____
Report Card /Transcript _____
IEP (if applicable) _____

Student ID# _____
Start Date: _____
Sent for records: ____ / ____ / ____

EMERGENCY MEDICAL INFORMATION

Student's Physician of Health Care: _____

Physician's Address: _____ Phone: ( ) _____

Health Insurance Policy Name: _____ Policy Number: _____

Is your child subject to a condition which may cause emergencies such as epilepsy, diabetes, fainting, allergies, asthma, etc.? Yes _____ No _____ If yes, please explain _____

Is your child taking any medication for the above mentioned condition or any other condition? Yes _____ No _____

*****If yes, please request a medication permission form from the main office to give our staff permission to administer medication.**

Does your child have any health conditions that may limit participation in strenuous activities such as physical education or athletics? Yes _____ No _____ If so, please explain _____

_____

Has your child had chicken pox? Yes ___ No ___ Has your child been immunized for chicken pox? Yes ___ No ___

Mother/Guardian Information:

(please check one) Parent _____ Guardian _____ *(provide documents)* Deceased _____ Joint Custody _____ *(provide documents)*

Last Name: _____ First Name: _____

Address: *(if different from student)*

_____

(Street Address) *(City)* *(Zip Code)*

Email Address:

_____@_____.___

Home Phone: ( ) _____ Cell Phone: ( ) _____

Employer: _____ Occupation: _____

Business Address: _____ Business Phone: ( ) _____

Marital Status: Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

Father/Guardian Information:

(please check one) Parent ____ Guardian _____ *(provide documents)* Deceased _____ Joint Custody _____ *(provide documents)*

Last Name: _____ First Name: _____

Address: *(if different from student)*

_____

(Street Address) *(City)* *(Zip Code)*

Email Address:

_____@_____.___

Home Phone: ( ) _____ Cell Phone: ( ) _____

Employer: _____ Occupation: _____

Business Address: _____ Business Phone: ( ) _____

Marital Status: Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

Emergency Contact(s) Information:

#1 Name: _____ Relationship to Student: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

#2 Name: _____ Relationship to Student: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

#3 Name: _____ Relationship to Student: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

#4 Name: _____ Relationship to Student: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

#5 Name: _____ Relationship to Student: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Parent/Guardian's Signature _____ **Date:** _____

***NOTE: Falsification of information contained in this application will immediately void such agreement and result in said child being dropped from Barack Obama Leadership Academy.**

CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

For Provider Use Only:	Date of Admission	Date of Discharge

Name of Child (Last, First, Middle Initial)			Child's Date of Birth
Address (Number and Street, Building/Apartment Number)	City	State	Zip Code

Parent/Legal Guardian's Name	Home Phone ( )	Parent/Legal Guardian's Name (Optional)	Home Phone ( )
Home Address (if not child's address)	Cell Phone ( )	Home Address (if not child's address)	Cell Phone ( )
City / State	Zip Code	City / State	Zip Code
Email Address (optional)		Email Address	
Employer Name	Work Phone ( )	Employer Name	Work Phone ( )

Name of Child's Physician or Health Clinic	Physician's or Health Clinic's Phone Number ( )
Hospital Preferred for Emergency Treatment (optional)	
Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary.)	

BCAL-3731 (Rev. 7-18) Previous edition 6-17 may be used.

See Reverse Side

Emergency Contact & Release of Child: List all individuals, including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)

1.	( )	( )
2.	( )	( )
3.	( )	( )

Release of Child Only: List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)

1.	( )	2.	( )
3.	( )	4.	( )

Parent/Legal Guardian Initials:

_____I give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical treatment for the above named minor child while in care.

I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.

Signature of Parent or Guardian — Date Signed

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials

LARA is an equal opportunity employer/program.

AUTHORITY: 1973 PA 116
COMPLETION: Required
PENALTY: Rule Violation Citation.

BCAL-3731 (Rev. 7-18) Previous edition 6-17may be used.

BARACK OBAMA
LEADERSHIP ACADEMY

FIELD TRIP INFORMATION

I hereby give permission to Barack Obama Leadership Academy for my child to be transported in a vehicle and/or participate in field trips.

Signature of Parent/Guardian: _____

Date signed: _____

PERMISSION FOR USE OF MEDIA IMAGES

I hereby give my permission to use photographs, reproductions and/or sound reproductions of my child for promotional purposes. Such activities may include advertising, publicity and promotion of school events (plays, open house, etc.)

Signature of Parent/Guardian: _____

Date signed: _____

BARACK OBAMA
LEADERSHIP ACADEMY

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10800 E. Canfield
Detroit, MI 48214
(313) 823-6000 / FAX (313) 823-9748

RELEASE OF STUDENT RECORDS FORM

Enrollment Date: _____

Name of School _____

Address _____

City, State, Zip Code _____

Re: Release & forward student records for:

_____ _____ _____
Student's Name Date of Birth Grade

***Include in the records the transcript, Individualized Education Plan - (IEP) if applicable, standardized test scores, health record, disciplinary history and any other pertinent information that will enhance the student's education.**

Forward records to:
Barack Obama Leadership Academy
Attn: Records Clerk
10800 E. Canfield
Detroit, MI 48214

Student Residency Questionnaire _____

School Name: **Barack Obama Leadership Academy**

Student's Name: _____ Grade: _____

Age: _____ D.O.B.: _____ Any Siblings enrolled?: ☐ YES ☐ NO

Address: _____ City: _____ Zip: _____

Is this address **Temporary** or **Permanent**? (circle one)

Parent/Guardian: _____ Phone/Pager: _____

This questionnaire is in compliance with the McKinney-Vento Act, U.S.C. 42 11431 et seq. It is given to ALL students to ensure our academy remains in compliance with federal law. Your answers will determine if the student meets eligibility requirements for services under the McKinney-Vento Act.

The student lives in the following situation (you can choose more than one):

- ☐ House or apartment with parent or guardian
- ☐ Emergency shelter or transitional housing* ☐ Motel/Hotel*, Car, or Campground*
- ☐ Public or private place not designed for or ordinarily used as regular sleeping accommodation for humans, including cars, parks, public spaces, abandoned buildings, substandard housing, or bus or train stations*
- ☐ Foster care placement for 6 months or less*
- ☐ Long-term, stable, cooperative living arrangement. *If you are in temporary, shared housing with friends, family or others due to (check all that apply):*
  - ☐ Loss of personal housing* (due to reasons such as eviction, inability to pay rent, destruction or damage to home, abuse or neglect, unhealthy conditions, parental abandonment or incarceration)
  - ☐ Economic Hardship* ☐ Waiting on a house or apartment*
  - ☐ Loss of employment* ☐ Parent/Guardian is deployed*
  - ☐ Other, (please explain):_____*

Are you under the age of 18 and living apart from your parents or guardians? ☐ YES ☐ NO

Residency and Educational Rights

Students without fixed, regular, and adequate living situations have the following rights:

1) Immediate enrollment in the school they last attended or the local school where they are currently staying even if they do not have all of the documents normally required at the time of enrollment without fear of being separated or treated differently due to their housing situations;
2) Transportation to the school of origin for the regular school days;
3) Access to free meals, Title I and other educational programs, and transportation to extra-curricular activities to the same extent that is offered to other students.

Any questions about these rights can be directed the school McKinney-Vento Liaison at (313) 823-6000 Ext. 203 or the State Coordinator at (734) 494-2018.

By signing below, I acknowledge that I have received and understand the above rights.

_____

Signature of Parent /Guardian/Unattached Youth *Date*

_____

Signature of McKinney-Vento Liaison *Date*

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	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)			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?
☐	☐	☐	1 Allergies or Reactions (for example, food, medication or other)
☐	☐	☐	2 Hay Fever, Asthma, or Wheezing
☐	☐	☐	3 Eczema or Frequent Skin Rashes
☐	☐	☐	4 Convulsions/Seizures
☐	☐	☐	5 Heart Trouble
☐	☐	☐	6 Diabetes
☐	☐	☐	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements
☐	☐	☐	9 Shortness of Breath
☐	☐	☐	10 Speech Problems
☐	☐	☐	11 Menstrual Problems
☐	☐	☐	12 Dental Problems: Date of Last Exam / /
☐	☐	☐	Other (please describe):
☐	☐		Does your child take any medication(s) regularly?
Reason for Medication			

Birth History:

Are there any current or past diagnosis(es) ☐ Yes ☐ No

If yes, please describe:

If yes, list medications:

_____ / / _____
Parent/Guardian Signature Date

Was the health history reviewed by a health professional?
☐ Yes ☐ No *Examiner's Initials:* _____

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
☐	☐	VISION Date: / /	Visual Acuity			
			Muscle Imbalance			
			Other:			
☐	☐	HEARING Date: / /	Audiometer			
			Other:			
☐	☐	URINALYSIS Date: / /	Sugar			
			Albumin			
			Microscopic			
☐	☐	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl			

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
☐	☐	Other:	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading:			
☐	☐	TUBERCULIN Date: / /	Type: Neg.: ☐ Pos.: ☐ ____ mm			

NOTE: 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	
Hepatitis B (HepB)	1	3
	2	
DTaP/DTP/DT/Td	1	4
	2	5
	3	6
Tdap	1	
Haemophilus Influenzae type b (HIB)	1	3
	2	4
Polio (IPV/OPV)	1	3
	2	4
Pneumococcal Conjugate (PCV7/PCV13)	1	3
	2	4
Rotavirus (RV1/RV5)	1	3
	2	
Measles,Mumps, Rubella (MMR)	1	2
Varicella (Chickenpox)	1	2

History of Chickenpox Disease? ☐ Yes ☐ No If yes, date:

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (HepA)	1	2
Influenza (IIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	2	
OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	1	
	2	
	3	

Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable

*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.

Parent/Guardian refused Immunizations: ☐

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	
☐	☐	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:
☐	☐	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): ☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ 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.

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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.