



BARACK OBAMA LEADERSHIP ACADEMY

Enrollment Application Grades K-8

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

Barack Obama Leadership Academy | 10800 E. Canfield Street | Detroit, MI 48214 (313) 823-6000

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: _____



B A R A C K O B A M A
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: _____



B A R A C K O B A M A
L E A D E R S H I P A C A D E M Y

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**

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)			
Address (Number and Street, Building/Apartment Number)			Child's Date of Birth
		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.

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

BARACK OBAMA LEADERSHIP ACADEMY

TITLE I

SCHOOL - PARENT - STUDENT COMPACT

The School Parent Compact will describe school-parent compact will be jointly developed with parents and family members and the compact outlines how parents, the entire school staff, and students will share in the responsibility for improved student academic achievement and the means by which the school and the parents will build and develop partnerships to help children achieve the State's high standards (ESSA, Section 1116(d)).

School

The school understands the importance of the school experience to every student and their role as educators and models. Therefore, the school agrees to carry out the following responsibilities to the best of their ability:

- Provide high-quality curriculum and instruction in a supportive and effective learning environment that enables the children served under this part to meet the challenging State academic standards (required)
- Address the importance of communication between teachers and parents on an ongoing basis through, at a minimum—
 - parent-teacher conferences in elementary schools, at least annually, during which the compact shall be discussed as the compact relates to the individual child's achievement
 - frequent reports to parents on their children's progress;
 - reasonable access to staff, opportunities to volunteer and participate in their child's class, and observation of classroom activities; and
 - Ensuring regular two-way, meaningful communication between family members and school staff and, to the extent practicable, in a language that family members can understand. (required) (ESSA, Section 1116(d)(1-2))
- Treat each child with dignity and respect
- Strive to address the individual needs of the student
- Acknowledge that parents are vital to the success of child and school
- Provide a safe, positive and healthy learning environment
- Assure every student access to quality learning experiences
- Assure that the school staff communicates clear expectations for performance to both students and parents

Parent

The parent understands that participation in his/her student's education will help his/her achievement and attitude. Therefore, the parent will continue to carry out the following responsibilities to the best of his/her ability:

- Volunteering in their child's classroom (required)
- Supporting their child's learning (required)
- Participating, as appropriate, in decisions relating to the education of their child and positive use of extracurricular time (required)
- Create a home atmosphere that supports learning
- Send the student to school on time, well-fed, and well-rested on a regular basis
- Attend school functions and conference

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

SECTION I - HEALTH HISTORY

<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 5%;">Yes</th> <th style="width: 5%;">No</th> <th style="width: 5%;">Resolvent</th> <th style="width: 85%;"># Is your child having any of the problems listed below?</th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>1. Allergies or Reactions (for example, food, medication or other)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>2. Hay Fever, Asthma, or Wheezing</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>3. Eczema or Frequent Skin Rashes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>4. Convulsions/Seizures</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>5. Heart Trouble</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>6. Diabetes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>7. Frequent Colds, Sore Throats, Earaches (4 or more per year)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>8. Trouble with Passing Urine or Bowel Movements</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>9. Shortness of Breath</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>10. Speech Problems</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>11. Menstrual Problems</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>12. Dental Problems: Date of Last Exam / /</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other (please describe):</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Does your child take any medication(s) regularly?</td> </tr> <tr> <td colspan="4">Reason for Medication</td> </tr> </table>	Yes	No	Resolvent	# 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"/>	<input type="checkbox"/>	Does your child take any medication(s) regularly?	Reason for Medication				<p>Birth History:</p> <p>Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe:</p> <p>If yes, list medications:</p> <p>Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____</p>
Yes	No	Resolvent	# Is your child having any of the problems listed below?																																																														
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SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred Under Care	No	Yes	Was child tested for:	Test results:	Normal	Referred Under Care
<input type="checkbox"/>	<input type="checkbox"/>	VISION Date: / /	Visual Acuity Muscle Imbalance Other:			<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT Other:	Height Weight Other:		
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: / /	Audiometer Other:			<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE	Reading: →		
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: / /	Sugar Albumin Microscopic			<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN Date: / /	Type: _____ Neg: <input type="checkbox"/> Pos: <input type="checkbox"/> min		
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl →			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:

SECTION III - IMMUNIZATIONS

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

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	2
	2			2	
DTaP/DTP/DT/Td	1	4	Influenza (IV/LAIV)	1	3
	2	5		2	4
	3	6	Meningococcal (MCV4 / MPSV4)	1	2
Tdap	1		Human Papillomavirus *(HPV9/HPV4/HPV2)	1	3
Haemophilus Influenzae type b (HIB)	1	3		2	
	2	4	OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
Polio (IPV/OPV)	1	3		1	
	2	4		2	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	3		
	2	4	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable		
Rotavirus (RV1/RV5)	1	3	*NOTE: According to Public Act 388 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				
Measles, Mumps, Rubella (MMR)	1	2	Parent/Guardian refused Immunizations: <input type="checkbox"/>		
Varicella (Chickenpox)	1	2			
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____					
I certify that the Immunization dates are true to the best of my knowledge					
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:
<input type="checkbox"/>	<input type="checkbox"/>	_____
<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
<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Recommendations _____		

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

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

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.

Barack Obama Leadership Academy

10800 E. Canfield, Detroit, MI 48214

Ph: 313-823-6000 Fax: 313-823-9748

Marketing Survey

How did you hear about BOLA?

Student(s) Currently Attending

Billboard (St. Veronica Display Board)

Yard Sign

Event Flyer/Poster

Banner/Sign

Newspaper Advertisement

Email Advertisement

Web Page

Word of Mouth

Other (unspecified)

Former Employee

Walk In

Previous Student/Returned Due to Dissatisfaction at other School

Total Survey Responses as of

Survey Responses