



Warren Consolidated Schools  
31300 Anita  
Warren, Michigan 48093  
888-4WCSKIDS  
(888-492-7543)

## WORLD OF FOURS ONLINE REGISTRATION CHECKLIST 2020-2021

| Check when complete      | Required Documents   |
|--------------------------|--|
| <input type="checkbox"/> | Completed Student Registration Information Card  |
| <input type="checkbox"/> | Original Birth Certificate   |
| <input type="checkbox"/> | Immunization Records   |
| <input type="checkbox"/> | Completed Health Appraisal (Must Be Completed & Signed By Parent and Doctor/Physician)   |
| <input type="checkbox"/> | <u>Current Mortgage OR Lease Agreement OR Property Tax Statement</u><br><i>If you are NOT the homeowner/leaseholder you will need a notarized letter from the homeowner/leaseholder stating that you reside with them or in their home. In addition, you are required to provide documentation of the Mortgage OR Lease OR Property Tax Statement for the person with whom you reside.</i> |
| <input type="checkbox"/> | <u>Current Bill</u> (e.g. Utility, Cellular Telephone, Doctor, Insurance Bill, etc.). Bill must have homeowner's/parent's name and address on it. <i>Shut off notices will not be accepted.</i>  |

The Board of Education of the Warren Consolidated School District complies with all federal and state laws and regulations prohibiting discrimination and with all requirements and regulations of the United States Department of Education and the Michigan State Department of Education. No person, on the basis of sex, race, color, religion, national origin or ancestry, age, marital status, limited English or handicap shall be discriminated against, excluded from participation in, denied the benefits of, or otherwise subjected to discrimination in any program or employment practice or activity.



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## STUDENT REGISTRATION INFORMATION CARD

|                       |   |                      |        |
|-----------------------|---|----------------------|--------|
| Last Name             | First Name                              | Middle Name          |        |
| Address               | Apt.                                    | City                 |        |
| Zip Code + 4 digit    |   |                      |        |
| Birth Date            | Place of Birth – City, State or Country | Parent Email Address |        |
| Home Telephone Number | Cellular Telephone Number               | Grade                | Gender |

**Residency:** Indicate in which type of residence the student lives.

- ☐ Fixed residence (parent/guardian owns, mortgages, or rents a house, apartment, or trailer).
- ☐ Transitional residence (motel, hotel, camp ground, shelter, car, or public space; sharing the housing of others due to housing loss; foster placement).

### Racial Ethnic Survey – Two part question required by the Federal Government

**Part One: Is 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.)

**Part Two: Racial/Ethnic (Check all that apply):** ☐ Alaskan or American Indian ☐ Asian  
☐ African American ☐ Hawaiian or Pacific Islander ☐ Caucasian

List ALL Schools Attended (Include Name of School, City, State, and Phone Number): \_\_\_\_\_

### Home Language Survey (To be filled out for ALL students)

Primary Language:

1. Is your **child's native language** a language other than English? Y or N What is the language? \_\_\_\_\_

**Note:** The child's native tongue/language is the **primary** language most often spoken by the student.

Home Language:

2. Is the **primary language used in your child's home** a language other than English? Y or N

What is the language? \_\_\_\_\_

**Note:** The primary language is the dominant language used at home regardless of the language spoken by the student.

If the student was born outside the U.S.A., when did the student arrive in the U.S.A.? \_\_\_\_\_

If the student was born outside the U.S.A., record the date the student first attended school in the U.S.A. \_\_\_\_\_

Has the student been identified or have they received Bilingual/ESL services in another district?

If yes, what district? \_\_\_\_\_

### Special Education / 504 (If yes, parents must provide the most recent IEP or 504 plan at the time of registration)

Does your child: Receive Special Education services? ☐ Yes ☐ No Parent Initials \_\_\_\_\_

Have a 504 Plan? ☐ Yes ☐ No Parent Initials \_\_\_\_\_

Please indicate any health problems which you believe school personnel should be aware of: \_\_\_\_\_

DA Code: \_\_\_\_\_ Street Code: \_\_\_\_\_ ES# \_\_\_\_\_ MS# \_\_\_\_\_ HS# \_\_\_\_\_



**Parent/Guardian Information: With whom does the child reside? (Please check appropriate status):**

- ☐ Both Parents    ☐ Father Only    ☐ Father/Stepmother    ☐ Mother Only    ☐ Mother/Stepfather  
☐ Legal Guardian    ☐ Court Placed    ☐ Relative    ☐ Foster Home    ☐ Divorced, joint custody

Is either Parent/Guardian an active military member? ☐ Yes ☐ No

Are there any custody issues the school should be aware of? ☐ Yes ☐ No

Do you have guardianship, custody papers, court or foster care placement letters? ☐ Yes ☐ No

**(If yes, please explain and provide supporting documentation)**

Male Parent/Guardian: \_\_\_\_\_ Area Code & Alternate Number: \_\_\_\_\_

Email: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Area Code & Work Number: \_\_\_\_\_

Female Parent/Guardian: \_\_\_\_\_ Area Code & Alternative Number: \_\_\_\_\_

Email: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Area Code & Work Number: \_\_\_\_\_

Parent living elsewhere: \_\_\_\_\_

Address

Apt

City/State

Zip code + 4 digit

Area Code and Home Number

Area Code and Work Number

Area Code and Alternate Number

**Emergency Contact Information:** The individuals listed below have authorization to pick up my child and can be reached during school hours at the number listed.

Name Relationship Area Code & Telephone Number

Name Relationship Area Code & Telephone Number

Name Relationship Area Code & Telephone Number

Warren Consolidated Schools has designated the following as Directory Information: student's name, address, telephone number, date and place of birth, grade, major field of study, participation in school activities, honors and awards, other similar information (alumni associations, height and weight of athletes) and information generally found in a yearbook. Directory information can be provided to any individual, other than for-profit organizations, even without the written permission of a parent. If you wish to have Directory Information totally withheld from release, please check the box below.

☐ Until further notice, withhold all Directory Information from the student listed on this form.

Warren Consolidated Schools and the local media regularly cover school events for news, public relations, cable TV or other not-for-profit purposes. This would include photographs, video and audio taping and interviews. If you wish your student to be excluded from video tapes, audio tapes, photographs or interviews in conjunction with school or school district events, performances, or activities, please check the box below.

☐ Until further notice, exclude the student shown on this form from all school, school district, or news media video and audio taping, photography or interviews.

**Verification of Data:** I affirm that as the parent/guardian, all information provided in this document is true and accurate, and my child and I reside at the listed address. I understand any false information provided by me may result in the immediate removal of this student from Warren Consolidated Schools.

Signature of Parent/Guardian

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

**SECTION I - HEALTH HISTORY**

| Yes                              | No                       | Resolved                 | # Is your child having any of the problems listed below?          |
|----------------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> | 1 Allergies or Reactions (for example, food, medication or other) |
| <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> | 2 Hay Fever, Asthma, or Wheezing                                  |
| <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> | 3 Eczema or Frequent Skin Rashes                                  |
| <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> | 4 Convulsions/Seizures  |
| <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> | 5 Heart Trouble   |
| <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> | 6 Diabetes  |
| <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> | 7 Frequent Colds, Sore Throats, Earaches (4 or more per year)     |
| <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> | 8 Trouble with Passing Urine or Bowel Movements                   |
| <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> | 9 Shortness of Breath   |
| <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> | 10 Speech Problems  |
| <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> | 11 Menstrual Problems   |
| <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> | 12 Dental Problems: Date of Last Exam      /      /               |
| <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> | Other (please describe): _____<br>_____                           |
| <input type="checkbox"/>         | <input type="checkbox"/> |                          | Does your child take any medication(s) regularly?                 |
|                                  |                          |                          | Reason for Medication   |
|                                  |                          |                          |   |
|                                  |                          |                          | /      /  |
| <b>Parent/Guardian Signature</b> |                          |                          | Date  |



⇒

| Birth History:   |  |
|--|--|
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| If yes, please describe:   |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| If yes, list medications:  |  |
|  |  |
|  |  |
| Was the health history reviewed by a health professional?  |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Examiner's Initials:</b> _____           |  |

## SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

## Tests and Measurements

| No                       | Yes                      | Was child tested for:                    | Test results:                                     | Normal   | Referred                 | Under Care               | No                       | Yes                      | Was child tested for:                     | Test results:   | Normal                   | Referred                 | Under Care               |
|--------------------------|--------------------------|--|---|--|--------------------------|--------------------------|--------------------------|--------------------------|---|---|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | VISION<br>Date: ____/____/____           | Visual Acuity<br>Muscle Imbalance<br>Other: _____ | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HEIGHT & WEIGHT<br>Other: _____           | Height<br>Weight<br>Other   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | HEARING<br>Date: ____/____/____          | Audiometer<br>Other: _____                        | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HEMOGLOBIN / HEMATOCRIT<br>BLOOD PRESSURE | <br>Reading: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | URINALYSIS<br>Date: ____/____/____       | Sugar<br>Albumin<br>Microscopic                   | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | TUBERCULIN<br>Date: ____/____/____        | Type: _____<br>Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> ____ mm                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | BLOOD LEAD LEVEL<br>Date: ____/____/____ | Level _____ ug/dl                                 |  <b>NOTE:</b> Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above. |                          |                          |                          |                          |   |   |                          |                          |                          |

### Examinations and/or Inspections

|   |  |
|---|--|
| Essential Findings Deviating from Normal: |  |
|   |  |
|   |  |
|   |  |
| Exam Date:       /       /                |  |



| <b>SECTION III - IMMUNIZATIONS</b><br><small>Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*</small> |  |   |  |  |                    |
|---|--|---|--|--|--------------------|
| VACCINES (Circle Type)  | DATE ADMINISTERED<br><small>MM/DD/YYYY</small> |   | VACCINES (Circle Type)   | DATE ADMINISTERED<br><small>MM/DD/YYYY</small> |                    |
| Hepatitis B<br>(HepB)   | 1  | 3 | Hepatitis A (HepA)   | 1  | 2                  |
|   | 2  |   |  | 1  | 3                  |
| DTaP/DTP/DT/Td  | 1  | 4 | Influenza (IIV/LAIV)   | 2  | 4                  |
|   | 2  | 5 |  | Meningococcal (MCV4 / MPSV4)                   | 1                  |
|   | 3  | 6 | Human Papillomavirus<br>(HPV9/HPV4/HPV2)   | 1  | 3                  |
| Tdap  | 1  |   | 2  |  |                    |
| Haemophilus Influenzae<br>type b (HIB)  | 1  | 3 | OTHER Vaccines<br>Specify Date & Type  | Type of Vaccine(s)                             | Date of Vaccine(s) |
|   | 2  | 4 |  | 1  |                    |
| Polio<br>(IPV/OPV)  | 1  | 3 |  | 2  |                    |
|   | 2  | 4 | 3  |  |                    |
| Pneumococcal Conjugate<br>(PCV7/PCV13)  | 1  | 3 | Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable   |  |                    |
|   | 2  | 4 | *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. |  |                    |
| Rotavirus (RV1/RV5)   | 1  | 3 |  |  |                    |
|   | 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  |  |   |  |  |                    |
| _____<br>Health Professional's Signature  |  |   | _____<br>Title   |  | _____<br>Date      |

|                       |     | <b>SECTION IV - RECOMMENDATIONS</b><br><small>(Required for Child Care and Head Start/Early Head Start)</small>   |
|-----------------------|-----|---|
| No                    | Yes | <input type="checkbox"/> <input type="checkbox"/> Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain:<br>_____<br>_____  |
| No                    | Yes | <input type="checkbox"/> <input type="checkbox"/> Should the child's activity be restricted because of any physical defect or illness?<br>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<br>_____<br>_____ |
| Other Recommendations |     |   |
|                       |     |   |

| <b>SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)</b>  |
|---|
| I have examined _____'s teeth. As a result of this examination, my recommendation for treatment is: _____<br>child's name |
|   |
| _____<br>Dentist's Signature  |
| _____<br>Date   |

| <b>PHYSICIAN'S SIGNATURE</b>  |               |  |                            |
|-------------------------------|---------------|--|----------------------------|
| _____<br>Examiner's Signature | _____<br>Date | _____<br>Examiner's Name (Print or Type) | _____<br>Degree or License |
| _____<br>Number & Street      | _____<br>City | MI _____<br>ZIP Code                     | (_____) _____<br>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.

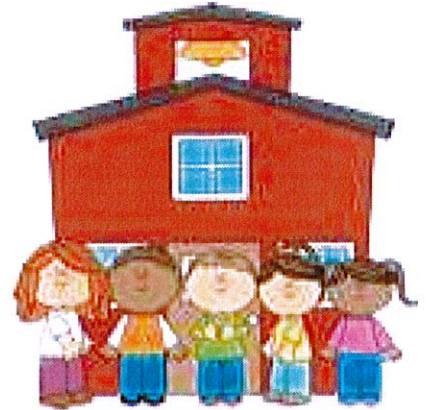
## **IMMUNIZATIONS ARE REQUIRED**

The State of Michigan & the Macomb County Immunization Ordinance requires children to be adequately immunized to start school.

### **TO ENTER SCHOOL**

Your child must have the following vaccines:

- 1 dose of DTP/DTaP
  - ☐ Diphtheria, Tetanus, Pertussis (Whooping Cough)
- 1 dose of Polio
- 1 dose of MMR – Measles, Mumps & Rubella (must be received on or after the 1<sup>st</sup> birthday)
  - ☐ **OR** Laboratory proof of immunity
- 1 dose of Hepatitis B
  - ☐ **OR** Laboratory proof of immunity
- 1 dose of Varicella (chickenpox) (must be received on or after the 1<sup>st</sup> birthday)
  - ☐ **OR** Laboratory proof of varicella immunity
  - ☐ **OR** Provide a written statement from a parent/guardian or doctor verifying the child already had chickenpox disease



### **TO REMAIN IN SCHOOL**

**Children 4-6 Years of Age Must Have the Following Minimum Vaccines:**

- 4 doses of DTP/DTaP with 1 dose on or after the 4<sup>th</sup> birthday
- 4 doses of Polio. If dose #3 was given on or after the 4<sup>th</sup> birthday, only 3 doses are needed.
- 2 doses of MMR and Varicella on or after the 1<sup>st</sup> birthday, at least 28 days apart from each other and/or the nasal flu vaccine
- 3 doses of Hepatitis B
- Appropriate spacing between all vaccines is essential for the development of adequate immunity. A complete date (month, day, and year) for each vaccine is required. You will be contacted if there is a concern about the spacing of your child's vaccines.

### **SPECIAL NOTES**

- **Always bring your child's immunization record to your doctor or Health Department clinic.**
- Get immunizations on time to avoid the last minute rush.
- Keep your child's immunization record in a safe place.



# OBTAINING YOUR CHILD'S BIRTH CERTIFICATE

Your child's birth certificate may be obtained from the county in which your child was born. Macomb, Oakland and Wayne counties all have websites and contact information listed below.

## *Frequently Asked Questions*

**Who can get a copy of my child's birth certificate?** Anyone listed on the birth certificate or legal guardian.

**How much does it cost to get a birth certificate?** Fees vary from \$7.50 to \$25.

**What do I need to request a birth certificate?** A valid driver's license or 3 pieces of identification.

**Can I request a birth certificate online?** Yes, many counties provide an online service.

### ***Macomb County***

40 N. Main  
Mt Clemens MI 48043  
[www.macombcountymi.gov](http://www.macombcountymi.gov)  
586-469-5205

### ***Oakland County***

[www.oakgov.com](http://www.oakgov.com)  
248-858-0581

### ***Wayne County***

[www.waynecounty.com](http://www.waynecounty.com)

### ***Child Born In City of Detroit***

640 Temple St Suite 678  
Detroit, MI 48201

### ***Child Born Outside City of Detroit***

Office of Wayne County  
Clerk C/O Birth/Death  
Records Division 2  
Woodward Ave Room 201  
Detroit, MI 48226

For additional options visit:

<http://health.macombgov.org/Health-Programs-HPDC-SchoolImmunization>  
under additional forms.

