

# MACOMB ACADEMY

39092 Garfield Clinton Twp., MI 48038 Phone (586) 228-2201 Fax (586) 228-2210  
[macombacademy@macombacademy.net](mailto:macombacademy@macombacademy.net)

## REGISTRATION PACKET CHECKLIST

Please include the following documents with your **COMPLETED** Registration Packet. A student will **NOT** be considered for registration at Macomb Academy until all of these items are submitted to the Records Office. Please call if you have any questions or need assistance.

Please include the following completed signed documents:

- \_\_\_\_\_ Student Registration & Information Form
- \_\_\_\_\_ Student Release
- \_\_\_\_\_ Official Transcript from previous school(s)
- \_\_\_\_\_ F.A.P.E. Student Status Form, signed by previous school official
- \_\_\_\_\_ Authorization for Release of Records
- \_\_\_\_\_ Media Release
- \_\_\_\_\_ Guardian Verification Form, if applicable
- \_\_\_\_\_ Statement of Varicella Disease (Chicken Pox)
- \_\_\_\_\_ Medication Control Form and OTC Medication Administration Approval (Tylenol, Motrin, Benadryl)
- \_\_\_\_\_ Vehicle Information Form, if applicable
- \_\_\_\_\_ Macomb Intermediate School District Home Language Survey
- \_\_\_\_\_ Nonmedical Waiver, if applicable

Please provide **copies** of the following documents:

- |                                   |                                     |
|-----------------------------------|-------------------------------------|
| _____ Most recent IEP             | _____ Birth certificate             |
| _____ Most recent MET             | _____ Michigan ID card              |
| _____ TB test and results         | _____ Immunization record           |
| _____ Court approved guardianship | _____ including recent Tetanus Shot |
| _____ Power of Attorney proof     |                                     |
| _____ Social Security card        | _____ Certification of Completion   |

A student is **not** eligible for enrollment at Macomb Academy unless all of the required documents have been received prior to the student's anticipated admission date.

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## STUDENT REGISTRATION & INFORMATION

(Page 1 of 5)

Today's Date \_\_\_\_\_

Registration Year \_\_\_\_\_

Resident District \_\_\_\_\_

**\*\*PLEASE PRINT ALL REQUESTED INFORMATION\*\***

### STUDENT INFORMATION

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security No: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Birth Gender: Male Female (circle one)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Student Cell Phone: \_\_\_\_\_

Primary email: \_\_\_\_\_

Does student have a driver's license?  YES  NO If yes, please complete vehicle information sheet

### PARENT/GUARDIAN INFORMATION

Does the student have a legal guardian?  YES  NO

Parent  Guardian  Power of Attorney (check all that apply)

Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Primary email: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Primary email: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Does the student live with you?  YES  NO If no, with whom does the student live and what is his/her relationship to the student? \_\_\_\_\_

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## STUDENT REGISTRATION & INFORMATION

(Page 2 of 5)

### STUDENT EDUCATIONAL HISTORY

Last school attended: \_\_\_\_\_ Year: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

School District: \_\_\_\_\_ County: \_\_\_\_\_

Special Education Category: \_\_\_\_\_

Date of last Individual Educational Plan (IEP): \_\_\_\_\_

Certificate of Completion date: \_\_\_\_\_

### BENEFITS & SERVICES INFORMATION

Please check if student receives any of the following services/benefits:

\_\_\_\_ SSI (Supplemental Security Income from Social Security)

Agency Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_

Zip Code: \_\_\_\_\_

Phone number: \_\_\_\_\_

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

\_\_\_\_ Medicaid

Agency Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_

Zip Code: \_\_\_\_\_

Phone number: \_\_\_\_\_

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

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## \_\_\_ Community Mental Health (CMH) services

Agency Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_

Zip Code: \_\_\_\_\_

Phone number: \_\_\_\_\_

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

## \_\_\_ Michigan Rehabilitation Services (MRS)

Agency Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_

Zip Code: \_\_\_\_\_

Phone number: \_\_\_\_\_

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

## \_\_\_ Other Services

Agency Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_

Zip Code: \_\_\_\_\_

Phone number: \_\_\_\_\_

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

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## STUDENT REGISTRATION & INFORMATION

(Page 3 of 5)

### BENEFITS & SERVICES INFORMATION

Did the student receive any of these services?

- |   |  |
|---|--|
| <input type="checkbox"/> Social Work          | <input type="checkbox"/> Vision Impaired Teacher Consultant  |
| <input type="checkbox"/> Speech & Language    | <input type="checkbox"/> Orientation and Mobility Specialist |
| <input type="checkbox"/> ESL                  | <input type="checkbox"/> Deaf/Hard of Hearing Teacher        |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Consultant                          |
| <input type="checkbox"/> Physical Therapy     | <input type="checkbox"/> Audiologist                         |

### STUDENT EMPLOYMENT/VOLUNTEER/SCHOOL-BASED WORK EXPERIENCE HISTORY

#### WORK EXPERIENCE:

Employer name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact person/supervisor: \_\_\_\_\_

Please detail job duties: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there a work environment in which the student has had particular success and should pursue further? \_\_\_\_\_

Are there any special interests regarding the type of work the student would like to do and in which the student is skilled? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Briefly describe your student and any information that would be beneficial in planning his/her education, employment, and social skills development:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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## STUDENT REGISTRATION & INFORMATION

(Page 4 of 5)

### EMERGENCY CONTACT INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Which phone is primary contact during school hours?  HOME  CELL  WORK

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Which phone is primary contact during school hours?  HOME  CELL  WORK

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Which phone is primary contact during school hours?  HOME  CELL  WORK

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Which phone is primary contact during school hours?  HOME  CELL  WORK

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## STUDENT REGISTRATION & INFORMATION

(Page 5 of 5)

### PHYSICIAN INFORMATION

Physician name: \_\_\_\_\_

Address: \_\_\_\_\_

Preferred Hospital/Practice name: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Additional information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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## STUDENT RELEASE OF INFORMATION

Macomb Academy students are over the age of 18 and, therefore, legal adults. Because of this, the Academy may not release certain information to anyone other than the student's legal guardian, if applicable, without first receiving written permission from the student. This includes parents and other family members.

To help us provide students the best educational experience while attending Macomb Academy, we request each student to grant the Academy permission to release information to and otherwise communicate with the student's parent(s) and others listed below by completing this form and returning it to our office promptly.

Student Name (please print): \_\_\_\_\_

By signing this form, I give Macomb Academy permission to release information to and otherwise communicate with the following individual(s):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_

I understand that this Release is in effect throughout my enrollment at Macomb Academy unless/until I revoke permission in writing. I understand that I may add or remove individuals on this list at any time.

\_\_\_\_\_  
Student Signature Date

\_\_\_\_\_  
Guardian Signature Date



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## RACIAL/ETHNIC DECLARATION

All school districts are required by state and federal law to report the racial/ethnic origins of our student body as a group. This declaration is used for statistical purposes only and will **NOT** be kept as part of an individual students' record. Your cooperation regarding this effort is most appreciated.

### PLEASE CIRCLE ONE:

1. **AMERICAN INDIAN OR ALASKAN NATIVE:** A person having origins in North America, or who maintains cultural identification through tribal affiliation or community Recognition
2. **ASIAN AMERICAN:** A person having origins in the Far East or Southeast Asia
3. **BLACK OR AFRICAN AMERICAN:** A person having origins in any of the black racial groups in Africa
4. **HISPANIC OR LATINO:** A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin
5. **WHITE; NOT OF HISPANIC ORIGIN:** A person having origins in Europe, North Africa or the Middle East
6. **MULTI-RACIAL**
7. **HAWAIIAN OR PACIFIC ISLANDER**

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## Macomb Academy - Media Release

Here at Macomb Academy, we are always looking for ways to share happenings with our community. In order to do that, we will be initiating a larger emphasis on our social media platforms like Facebook, Twitter, and Instagram.

Macomb Academy would like to be able to showcase all of our students in their daily activities at school and/or jobsites. To do this, we will be photographing students (and staff) throughout the school year to highlight the great things being done that are not always seen.

We hope that you will consider allowing us to show **your name and image** on our social media platforms.

Sincerely,

Mrs. Mikelle Hillewaere  
Director

---

Student Name (please print): \_\_\_\_\_

**PLEASE ONLY CHECK ONE:**

\_\_\_\_\_ I give permission to publish photos and videos of me – including my full name – online and/or in print, including the yearbook.

\_\_\_\_\_ I give permission to publish videos and/or photos of me in the same media as described above, but would NOT like my name to be published.

\_\_\_\_\_ I **DO NOT** give permission for Macomb Academy to publish or release any photos or videos of me for any reason, including the yearbook.

---

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

---

Parent/Guardian Name \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\* This preference will be effective until changed, in writing, by the student or parent/guardian (if applicable). \*\*

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## AUTHORIZATION for the RELEASE OF RECORDS

I HEREBY authorize Macomb Academy to obtain school and educational records pertaining to the following person for educational purposes.

### MACOMB ACADEMY

**Mrs. Mikelle Hillewaere, Director**

39092 Garfield Rd-Clinton Township, MI 48038

Phone: (586) 228-2201 Fax: (586) 228-2210

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Date of Birth

### Requested Information

\_\_\_\_\_ Current IEP

\_\_\_\_\_ Psychological Report

\_\_\_\_\_ Current MET

\_\_\_\_\_ Social Worker Report

\_\_\_\_\_ Multidisciplinary Report

\_\_\_\_\_ Teacher Report

\_\_\_\_\_ Medical Report

\_\_\_\_\_ EDP (Educational Development Plan)

\_\_\_\_\_ **OFFICIAL** School Transcript with "Seal"

\_\_\_\_\_ MI Access Assessment or M-Step/MEAP Results

\_\_\_\_\_ UIC Number

\_\_\_\_\_  
Student/Guardian Signature (Parent, if under 18)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

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## GUARDIAN VERIFICATION FORM

**\*\*Please Print All Requested Information\*\***

I, \_\_\_\_\_, hereby certify that I have petitioned  
Probate Court and have been granted \_\_\_\_\_ Partial \_\_\_\_\_ Plenary Legal Guardianship of  
\_\_\_\_\_. This student is not to sign legal  
Student Name  
documents regarding school information.

\_\_\_\_\_  
Guardian Signature

\_\_\_\_\_  
Date

**MACOMB ACADEMY MUST BE PROVIDED WITH COPIES OF CURRENT COURT DOCUMENTS OF  
GUARDIANSHIP.  
UNLESS/UNTIL THESE DOCUMENTS ARE PROVIDED, WE MUST TREAT THE STUDENT AS  
HIS/HER OWN GUARDIAN.**

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## STATEMENT OF VARICELLA DISEASE (CHICKEN POX)

HAS YOUR STUDENT EVER HAD THE CHICKEN POX?  YES  VACCINATION

(If yes, please complete the bottom portion of this form.)

Macomb County Immunization Regulations require all students admitted to any public, private or parochial elementary or secondary school, day care center, camp or any other organized care or educational facility operating in Macomb County to present a certificate indicating dates of all required immunizations.

Complete the portion below only if your student has had varicella disease (chicken pox). This must be signed and witnessed at the student's school/child care program.

**\*\*Please Print All Information Requested\*\***

I certify that the student \_\_\_\_\_  
Last Name First Name M.I.

Birth Date Grade Date of School Enrollment

has had varicella disease(chicken pox) \_\_\_\_\_  
(when did varicella occur: age or date)

Printed Name of Parent/Legal Guardian Signature of Parent/Legal Guardian Date

Witnessed by School/Program Staff Date

School District:

School/Child Care Program: Macomb Academy

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## MEDICATION CONTROL FORM and OTC MEDICATION ADMINISTRATION APPROVAL

**\*\*Please Note Form *Must* Be Updated Every Year\*\***

Student: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Teacher: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

- I. Macomb Academy  **has permission**       **does not have permission** to provide over the counter medication, if needed to the student.  
Please check your preference. If no choice is indicated, no medication will be provided.  
 Motrin (ibuprofen)     Tylenol (acetaminophen)     Benadryl (allergy relief)

- II. \_\_\_\_\_ Check here if students **does not** take any medication

- III. Student takes the following prescribed medication(s) **AT HOME:**

|                     |              |                  |                |
|---------------------|--------------|------------------|----------------|
| 1. Medication _____ | Dosage _____ | Time Taken _____ | Comments _____ |
| 2. Medication _____ | Dosage _____ | Time Taken _____ | Comments _____ |
| 3. Medication _____ | Dosage _____ | Time Taken _____ | Comments _____ |
| 4. Medication _____ | Dosage _____ | Time Taken _____ | Comments _____ |

- IV. Student will bring and may take the following prescribed medication(s) **AT SCHOOL:**

|                     |              |                  |                |
|---------------------|--------------|------------------|----------------|
| 1. Medication _____ | Dosage _____ | Time Taken _____ | Comments _____ |
| 2. Medication _____ | Dosage _____ | Time Taken _____ | Comments _____ |
| 3. Medication _____ | Dosage _____ | Time Taken _____ | Comments _____ |
| 4. Medication _____ | Dosage _____ | Time Taken _____ | Comments _____ |

I give permission for the above medication(s) to be taken at school. These instructions are in compliance with the instructions of the physician.

Parent/Guardian Signature: \_\_\_\_\_ Student: \_\_\_\_\_ Date: \_\_\_\_\_

**IMPORTANT: All prescribed medication must be sent to school in the original prescription container and labeled with the date of the prescription, student's name, exact dosage and time to be taken. A new medication form must be completed whenever there is a change in medic**

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## STUDENT TRANSPORTATION INFORMATION

Student Name: \_\_\_\_\_

Please check one:

\_\_\_\_\_ I will be driving myself to school everyday

\_\_\_\_\_ I will drive myself to school occasionally

Make, Model & Year of Vehicle: \_\_\_\_\_

License Plate Number: \_\_\_\_\_

**OR**

Personal Transportation:

\_\_\_\_\_ I will be picked up and dropped off by a family member

Make, Model & Year of Vehicle: \_\_\_\_\_

License Plate Number: \_\_\_\_\_

**OR**

Community Transportation:

\_\_\_\_\_ SMART Bus

\_\_\_\_\_ Fixed Route

\_\_\_\_\_ Connector Service or Flex Service

**OR**

Other (please describe): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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## **MACOMB ACADEMY STUDENT STATUS FORM**

Free Appropriate Public Education (FAPE)

**\*\*Please Attach a Current IEP to this Completed Form\*\***

Today's Date \_\_\_\_\_

Student Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Gender: M F Parent(s) Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

District in which student resides: \_\_\_\_\_ Last evaluation date: \_\_\_\_\_

### Right to a Free Appropriate Public Education (FAPE)

- On \_\_\_\_\_ (date) it was determined that your student is a student with a disability under the Individuals with Disabilities Education Act (IDEA).
- As a student with a disability: he/she is entitled to receive a Free Appropriate Public Education (FAPE) from the public school
- The \_\_\_\_\_ public school district stands ready to provide a FAPE should you/your student choose to continue his/her education until age 26 or his/her acceptance of a diploma

This form verifies that, \_\_\_\_\_, the student, has not accepted his/her high school diploma, nor will a diploma be held for the student to obtain at a later date. In addition, an IEP (Individualized Education Plan) has identified his/her disability and plan of work, which includes transition goals for daily living skills and employability training to exit your district.

Therefore, the student, \_\_\_\_\_, is entitled to a Free Appropriate Public Education (FAPE) in the State of Michigan.

\_\_\_\_\_  
Signature of School Official

\_\_\_\_\_  
Position

\_\_\_\_\_  
School District

\_\_\_\_\_  
Date