

**MID PENINSULA SCHOOL**

**5055 ST. NICHOLAS RD**

**ROCK, MI 49880**

Phone: (906) 359-4387, 359-4390

Fax: (906) 359-4167

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**STUDENT RECORD REQUEST**

INFORMATION TO BE RELEASED FROM: *(Previous School)*

\_\_\_\_\_  
School, Agency, or Individual

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Fax

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

We are requesting the release of medical, educational, or specific program information including psychological reporting, IEPC reports, etc., for use in providing appropriate educational services, programs, or updating previous reports, for the following student(s):

| STUDENT'S NAME | GRADE | BIRTH DATE |
|----------------|-------|------------|
| _____          | _____ | _____      |
| _____          | _____ | _____      |
| _____          | _____ | _____      |
| _____          | _____ | _____      |

**Please mail records to: Mid Peninsula School, ATTN: Julie Koski, 5055 St. Nicholas Rd, Rock, MI 49880.**

PL 93-380, The Federal Family Educational Rights and Privacy Act, provides that written consent of the parent/guardian/eligible student IS NOT REQUIRED to release educational records to officials of other schools or school systems in which the student seeks or intends to enroll.

Written consent IS REQUIRED of a parent/guardian/eligible student when a request for student records involves NON SCHOOL individuals, agencies, or institutions.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Mid Peninsula School Registration Sheet

(Please Print)

Name: \_\_\_\_\_  
Last First Middle

Address: (Street) \_\_\_\_\_  
(mailing) \_\_\_\_\_  
(City, Zip) \_\_\_\_\_

Home Phone: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
County of Residence: \_\_\_\_\_

Entering Grade: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_  
( ) Female ( ) Male

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

Place of Birth: \_\_\_\_\_

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Name & Address of previous school: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Father's Name: \_\_\_\_\_

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

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

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

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

Cell Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

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

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

Place of Birth: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

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

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

Marital Status: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Educational Status: \_\_\_\_\_

Educational Status: \_\_\_\_\_

Kind of Work: \_\_\_\_\_

Kind of Work: \_\_\_\_\_

Place of Work: \_\_\_\_\_

Place of Work: \_\_\_\_\_

Phone # at Work: \_\_\_\_\_

Phone # at Work: \_\_\_\_\_

Step-Parents Name: \_\_\_\_\_

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

With whom is child living - if other than own parent: \_\_\_\_\_

Other children in the family:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Emergency contact:

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

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

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

Relation: \_\_\_\_\_

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

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

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

Relation: \_\_\_\_\_

Family Doctor: \_\_\_\_\_

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

Signature: \_\_\_\_\_

Date Registered: \_\_\_\_\_

# Student Residency Questionnaire

Your child may be eligible for additional educational services through McKinney-Vento Assistance Act.  
To determine your child's eligibility, please complete this form.

Student's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Birth Date \_\_\_\_\_ Grade \_\_\_\_\_ Sex: \_\_\_ Male \_\_\_ Female

1. Is the student's current address a temporary living arrangement? \_\_\_ Yes \_\_\_ No
2. Is this temporary living arrangement due to loss of housing or economic hardship? \_\_\_ yes \_\_\_ No

If you answered YES to the above questions, please complete the remainder of this form.  
If you answered NO, you may stop here.

Where is the student presently living? (Check one box)

- \_\_\_ Temporarily with another family in a house or apartment due to loss of housing or economic hardship
- \_\_\_ With an adult that is not a parent or legal guardian, or alone without an adult
- \_\_\_ Moving from place to place
- \_\_\_ In a hotel/motel
- \_\_\_ Staying in a shelter (family shelter, domestic violence shelter, youth shelter)
- \_\_\_ Waiting foster care placement or in a new foster care placement (less than 6 months)
- \_\_\_ In a car, park, campground, abandoned building or any other inadequate accommodation
- \_\_\_ In an emergency/transitional shelter
- \_\_\_ Unknown nighttime residence
- \_\_\_ Other \_\_\_\_\_

Please check your relational to this student:

- \_\_\_ Parent
- \_\_\_ Legal Guardian
- \_\_\_ Power of Attorney
- \_\_\_ Adult Caring for Student
- \_\_\_ Youth living without being in the physical custody of a parent or legal guardian

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*The undersigned certifies that the information provided is accurate.*

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***School Use Only***

- Copies to:
- |                          |                     |                      |
|--------------------------|---------------------|----------------------|
| 1) District Liason       | 4) School Counselor | 7) Classroom Teacher |
| 2) MSDS Data Person      | 5) Food Service     |                      |
| 3) Building Administrato | 6) CA 60            |                      |

## Mid Peninsula School District - Student Information Sheet upon Admission

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

**Medical History** - Has your child ever had any of the following?

|                  | Yes   | No    | Age   |               | Yes   | No    | Age   |
|------------------|-------|-------|-------|---------------|-------|-------|-------|
| Chicken Pox      | _____ | _____ | _____ | Diabetes      | _____ | _____ | _____ |
| Meningitis       | _____ | _____ | _____ | Pneumonia     | _____ | _____ | _____ |
| Rheumatic Fever  | _____ | _____ | _____ | Scarlet Fever | _____ | _____ | _____ |
| Seizure Disorder | _____ | _____ | _____ | Tuberculosis  | _____ | _____ | _____ |
| Other _____      | _____ | _____ | _____ |               |       |       |       |

**Health History** - Has your child have any of the problems listed?

|                                                                                         | Yes | No |
|-----------------------------------------------------------------------------------------|-----|----|
| Asthma, hay fever, wheezing or shortness of breath                                      |     |    |
| Broken Bones. If yes, Which ones.                                                       |     |    |
| Eczema or frequent skin rashes                                                          |     |    |
| Eye infections                                                                          |     |    |
| Frequent colds, sore throats, earaches (4 or more per year)                             |     |    |
| Heart Condition                                                                         |     |    |
| Hearing problems                                                                        |     |    |
| Vision problems                                                                         |     |    |
| Speech problems                                                                         |     |    |
| Stomach or intestinal problems                                                          |     |    |
| Trouble with passing urine or bowel movements (constipation, diarrhea, toilet training) |     |    |
| Emotional Problems                                                                      |     |    |
| Strep Throat                                                                            |     |    |
| Mononucleosis                                                                           |     |    |

**Surgical/Hospitalization History:**

Has your child had any surgeries or hospitalizations? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain and provide the year when it occurred;

Does your child tend to use his right hand or left hand? \_\_\_\_\_

Sleeping habits: Hours of sleep? \_\_\_\_\_

Does your child rest well (dreaming, tossing, bed-wetting, etc)? \_\_\_\_\_

Does your child have any habits, problems, or fears that you feel may be a problem? (animals, storms, being alone, bugs or insects, etc) \_\_\_\_\_

Include any other comments that might be important to the school in helping your child: \_\_\_\_\_

Person completing form \_\_\_\_\_

Relationship to student: \_\_\_\_\_ Date: \_\_\_\_\_

## My Allergies

|             |
|-------------|
| <b>Name</b> |
|-------------|

### Food Allergies

| Allergic to: | Medication prescribed: |
|--------------|------------------------|
|              |                        |
|              |                        |
|              |                        |
|              |                        |

### Natural/Seasonal Allergies

| Allergic to: | Medication prescribed: |
|--------------|------------------------|
|              |                        |
|              |                        |
|              |                        |
|              |                        |

### Animal Allergies

| Allergic to: | Medication prescribed: |
|--------------|------------------------|
|              |                        |
|              |                        |
|              |                        |
|              |                        |

### Medication Allergies

| Allergic to: | Medication prescribed: |
|--------------|------------------------|
|              |                        |
|              |                        |
|              |                        |
|              |                        |

### Other Allergies

| Allergic to: | Medication prescribed: |
|--------------|------------------------|
|              |                        |
|              |                        |
|              |                        |
|              |                        |

### Physician Information

|                 |
|-----------------|
| <b>Name:</b>    |
| <b>Address:</b> |
| <b>Phone:</b>   |

Eric VanDamme  
Superintendent, St. Services  
359-4387, Ext 7112



**Mid Peninsula Schools**  
*Where Workers Learn & Learning Works*  
5055 St. Nicholas 31<sup>st</sup> Rd  
Rock, MI 49880  
Fax, 359-4167  
[www.mpswolverines.com](http://www.mpswolverines.com)



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### **Consent for Disclosure of Immunization Information to Local and State Health Departments**

Immunizations are an important part of keeping our children healthy. Schools and State and Local health departments must monitor immunization levels to ensure that all communities are protected from potentially life-threatening diseases and, if necessary, respond promptly to an emerging public health threat. It is important that disease threats be minimized through the monitoring of students being immunized.

Sharing immunization and personally identifiable information including the student's name, Date of Birth, gender, and address with local and state health departments will help to keep your child safe from vaccine preventable diseases. The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. 1232g, requires written parental consent before personally identifiable information from your child's education records is disclosed to the health department. If your child is 18 or over, he or she is an "eligible student" and must provide consent for disclosures of information from his or her education records.

You may withdraw your consent to share this information in writing at any time.

Please contact the school nurse at 906-359-4387 Ext. 120 with any questions or concerns.

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I authorize Mid Peninsula Public Schools to release my child's immunization record to the Michigan Department of Health and Human Services and Local Health Department. I understand this information will be used to improve the quality and timeliness of immunization services and to help schools comply with Michigan Law. This includes any immunization information and limited personally identifiable information from the school.

Student's Name \_\_\_\_\_

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

\_\_\_\_\_  
Signature of Parent/Guardian or Eligible Student

Date: \_\_\_\_\_

\_\_\_\_\_  
Printed Parent/Guardian Name or Eligible Student