A.G.B.U. ALEX & MARIE MANOOGIAN SCHOOL
22001 Northwestern Highway • Southfield, Michigan 48075
Phone: 248-569-2988
Fax: 248-569-1346
Mrs. Sonia Kalfayan — *Principal of Elementary and Middle Schools*
Dr. Hosep Torossian — *Principal of High School*

Thank you for your interest in A.G.B.U. Alex and Marie Manoogian School. In order to be included in the lottery for the upcoming year or enrollment process, you must provide the following items listed below.

Transcripts (**High School Students ONLY**)

Most recent **report card**

Original **birth certificate** (This will be returned to Parent)

Current Physical (Health)

Form/Immunizations
Hearing and Vision Test
completed and **signed by physician**
Note: Hepatitis B & Chicken Pox vaccines are required for admission

Signed Record release form

Affirmation of Prior Discipline Record

Proof of Residency of Michigan

Admission to the Manoogian School will be determined on availability and cannot be processed until all of the above forms are submitted.

Due to the school closure, we are requesting you contact either Mrs. Kalfayan @ 248-763-2036 or Ms. Haigan @ 586-201-0596 to make necessary arrangements to drop off application and documents listed below. We will be making appointments for drop off starting in June.

Sincerely,
Administration Office

Enclosure

RECORD RELEASE FORM

A.G.B.U. ALEX & MARIE MANOOGIAN SCHOOL

22001 NORTHWESTERN HIGHWAY
SOUTHFIELD, MI 48075
www.manoogian.org
office (248) 569-2988 Fax (248) 569-1346

I hereby grant permission to have the complete cumulative record (including grades, test scores and other relevant data from Kindergarten to the present) released and sent to the A.G.B.U. Alex & Marie Manoogian School for the following student:

NAME OF STUDENT: _____

BIRTHDATE: _____ **GRADE:** _____

SIGNATURE OF PARENT/GUARDIAN: _____

RELATIONSHIP: _____ **DATE:** _____

SCHOOL PREVIOUSLY ATTENDED:

_____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

Information Requested:

- o All School Records including Discipline
- o Health Records
- o Cumulative Scholastic Achievement
- o Report Cards
- o Official Transcript
- o Testing Information
- o Alpha Test Results (if any)
- o Special Education (IEP, etc.)
- o Psychological Records (if any)
- o Cumulative Standardized Test Scores

Dates Requested: _____ (1st request) _____ (2nd request) _____ (3rd request)

Due to the provisions of the Federal Family Education Rights and Privacy Act of 1974, it will be necessary for you to provide us with a statement of release. This release signed by you will allow us to send for your child's school records.
Send records to address listed above. Thank you

A.G.B.U. Alex & Marie Manoogian School
22001 Northwestern Hwy, Southfield, MI 48075
248-569-2988

Affirmation of Prior Discipline Record

Please complete the information below. A willful false statement of this affirmation is a violation of the Student Code of Conduct and may result in the student's expulsion from A.G.B.U. Alex & Marie Manoogian School.

The undersigned affirms the student named below, has or has not been suspended or expelled from any public or private school in Michigan or any other place for an offense involving weapons, alcohol or drugs, or for the willful infliction of injury to another person or for any act of violence against persons and/or property committed on school premises, at any school-sponsored activity, or on a public or private conveyance providing transportation to and from a school or school-sponsored activity.

☐ Has Been Suspended or Expelled Student's Name _____

☐ Has NOT Been Suspended or Expelled Student's Name _____

If you checked "Has Been Suspended or Expelled" explain the circumstances in detail. Include the school name, dates of suspension or expulsion, and a description of the incident giving rise to the suspension or expulsion.

_____

_____

_____

Date: _____ Signature of Student: _____

Date: _____ Signature of Parent: _____

Yes _____ No _____ Have you ever voluntarily withdrawn from any school district prior to a disciplinary action, suspension/expulsion? If yes, include the school name, date of withdrawal and a description of the incident giving rise to the withdrawal.

_____

_____

Parents/Students must fill out the information above only and return to Manoogian School Office

<u>Information below will be filled out by previous school district</u>

Name of sending (former) school district: _____

Sending School: Please check one:

_____ According to our records, the information provided about by the parent/student is correct.

_____ According to our records, the information provided above by the parent/student is not correct.

If the student has been involved in offenses involving weapons, alcohol, drugs, or willful infliction of injury to persons or an act of violence against persons and/or property committed on school premises, at a school-sponsored activity, or on a public or private conveyance providing transportation to or from school or a school-sponsored activity, please forward appropriate disciplinary documentation.

School: _____ Telephone: _____

Signature of Sending School district Administrator & Title: _____ Date:

Please read and sign this form for each child and return with your application

A.G.B.U. ALEX & MARIE MANOOGIAN SCHOOL

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 students 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.

I authorize A.G.B.U. ALEX & MARIE MANOOGIAN SCHOOL *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: _____

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

_____ _____ MI _____ (_____) _____
Number & Street | City | 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.

A.G.B.U. Alex & Marie Manoogian School / Հ. Բ. Ը. Մ. Ալեք եւ Մարի Մանուկեան Վարժարան

22001 Northwestern Hwy., Southfield, MI 48075 / www. manoogian.org / Tel: 248-569-2988

OFFICAL ENROLLMENT FORM / Դիմումնագիր

CHARTER SCHOOL

OFFICE

PARENT

VERIFICATION CHECKLIST – FOR OFFICE USE ONLY

Birth Certificate: _____ Current Report Card: _____

Recent Physical Exam: ___ Transcript (High school): ___

Immunization Record: ___ Records Release Form: ____

Proof of Residency of Michigan: ____ e.g. utility/water bill

Grade Applying For: _____

Last Grade Completed: _____

Last School Attended: _____

School Year Applying For: _____

Please print

Enter student's full name as it appears on their birth certificate

Last Name / Աշակերտի Տեղեկութիւն | *First Name* | *Middle Name*

Birth Date (mm/dd/yy) | *Gender* (M/F) | *Birth Place* (City/State/Country) Ծննդավայր | *U.S Citizen*(Y/N) | If no, years in U.S.

Native American | Asian American

Hawaiian / Pacific | African American

Latin American | Caucasian

Race / Ethnicity: Please indicate student race / ethnicity

Primary Language in home | Soc. Sec. #

Is there a language other than English spoken in the home environment?
YES NO If yes, what language _____

Does your child speak a language other than English?
YES NO If yes, what language _____

Enroll Date (mm/dd/yy) | Entry Code | Resident District | Multiple Birth (Twins, Triplets, etc.) list birth order

Was your child receiving speech and /or language services at previous school? Yes No

Was your child receiving Special Education services at previous school? Yes No

Has your child been expelled or suspended from another school? Yes No

If yes, please explain:

Siblings

_____ Name ___/___/___ Birthdate

_____ Name ___/___/___ Birthdate

_____ Name ___/___/___ Birthdate

As the parent/legal guardian, I affirm all information provided within this form is true and accurate, and that my child and I reside at the listed address. The undersigned understands that it is his/her responsibility to inform the school office if and when any of the information set in this form changes. Failure to inform the school will subject the student to termination of enrollment in the school.

I, the undersigned, declare that I and the student for whom this application is submitted, physically resides in the state of Michigan, Furthermore, I understand that only residents of the state of Michigan may attend the A.G.B.U. Alex & Marie Manoogian School, which is a Public School Academy. I understand any false information made on this application may subject my child/children to termination effective immediately and legal penalties for perjury.

The A.G.B.U. Alex and Marie Manoogian School is a Michigan Public School Academy and does not discriminate on the basis of intellectual or athletic abilities, measure of achievement or aptitude, handicap status, religion, creed, race, sex or national origin.

Parent Signature | Date

OFFICAL ENROLLMENT FORM / Դիմումնագիր

Male / Guardian In Student Household

Last Name | *First Name* | *Middle Name & Suffix (Jr. III, etc)*

Birth Date (mm/dd/yy) | Relationship to student (Father / Stepfather etc.) | ☐ I am an Emergency Contact

Area Code | Primary/Home Phone | ext. | Area Code | Cell or Pager

Area Code | Work Phone | ext. | Area Code | Fax

Guardian Email Address | Education Level – Last Grade Completed or degree received

Female / Guardian In Student Household

Last Name | *First Name* | *Middle Name & Suffix (Jr. III, etc)*

Birth Date (mm/dd/yy) | Relationship to student (Mother / Stepmother etc.) | ☐ I am an Emergency Contact

Area Code | Primary/Home Phone | ext. | Area Code | Cell or Pager

Area Code | Work Phone | ext. | Area Code | Fax

Guardian Email Address | Education Level – Last Grade Completed or degree received

Student / Family Address

House # | Street Name | Apt # | City | Zip Code

Emergency Contacts

Name | Telephone # | Relationship to student

Name | Telephone # | Relationship to student

Name | Telephone # | Relationship to student

OFFICAL ENROLLMENT FORM / Դիմումնագիր

Parent Living Elsewhere

If Shared / non-custodial parent lives in a home other than the student

Last Name | *First Name* | *Middle Name & Suffix (Jr. III, etc)*

Birth Date (mm/dd/yy) | Relationship to student (Father / Mother.) | I am an Emergency Contact

Area Code | Primary/Home Phone | ext. | Area Code | Cell or Pager

Area Code | Work Phone | ext. | Area Code | Fax

Guardian Email Address | Education Level – Last Grade Completed or degree received

House # | Street Name | Apt # | City / State | Zip Code

Emergency Information - Physician and Insurance information

List Health Alert Information

List any medical conditions (allergies, health conditions etc.) or other information which you want teachers and office personnel to know. This information when entered, will be available for teachers to see in class on the PC desktop

First and Last Name of Physician | Area Code | Phone number

Preferred Hospital | City where hospital is located

Family Insurance Provider

Insurance Policy Number

Previous School Information

School – Full Name | Area Code | Phone Number

Address | City | State | Zip Code

Has this student ever been retained/held back
Please answer with yes or no

The grade student was retained/held back

OFFICAL ENROLLMENT FORM / Դիմումնագիր

Health Information - Vaccinations

Immunization waivers require a signed waiver form

Indicate any illnesses your child has had (i.e. **chickenpox**). Please indicate the illness and the approximate date your child had the illness.

Please list your child's immunization dates below or attach a copy of an updated immunization record

POLIO 1	**2**	**3**	**4**	**5**
DTP 1	**2**	**3**	**4**	**5**
MMR 1	**2**			
HEPATITUS B 1	**2**	**3**		
HIBS 1	**2**	**3**	**4**	
VARICELLA 1 (Chickenpox Vaccine)	**2**			

Please indicate Pass or Fail and the date tested

Hearing Test	**Vision Test**

Comments: