Dear Parents,

We are currently accepting applications for the Pre-School program for the 2020-2021 school year. Attached is an application, contract, and immunization form (health appraisal) for your child for the upcoming school year. Admission will be determined on availability and cannot be processed until all forms indicated below have been 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.

Please complete and return the following:

* School application
* Contract with the registration fee
* Original Birth Certificate
  (Office will make a copy and return the original)
* Immunization form needs to be completed and returned by September 8, 2020
  (must be signed by physician)
* Proof of Residency of Michigan

Sincerely,
Mrs. Sonia Kalfayan
Principal

Attachments

Days of attendance and prices subject to change due to COVID-19
# OFFICIAL ENROLLMENT FORM

## REQUIRED FOR PRESCHOOL

### Days Attending

<table>
<thead>
<tr>
<th>PK3</th>
<th>PK4</th>
</tr>
</thead>
<tbody>
<tr>
<td>M W F</td>
<td>M T W TH F</td>
</tr>
<tr>
<td>Full Day</td>
<td>A.M. Only</td>
</tr>
</tbody>
</table>

### Siblings

<table>
<thead>
<tr>
<th>Name</th>
<th>Birthdate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em><strong>/</strong></em>/___</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Birthdate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em><strong>/</strong></em>/___</td>
</tr>
</tbody>
</table>

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.
OFFICIAL ENROLLMENT FORM

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

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name &amp; Suffix (Jr. III, etc)</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Area Code</th>
<th>Primary/Home Phone</th>
<th>ext.</th>
<th>Area Code</th>
<th>Cell or Pager</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Area Code</th>
<th>Work Phone</th>
<th>ext.</th>
<th>Area Code</th>
<th>Fax</th>
</tr>
</thead>
</table>

Guardian Email Address

<table>
<thead>
<tr>
<th>House #</th>
<th>Street Name</th>
<th>Apt #</th>
<th>City / State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>First and Last Name of Physician</th>
<th>Area Code</th>
<th>Phone number</th>
</tr>
</thead>
</table>

Preferred Hospital

City where hospital is located

Family Insurance Provider

Insurance Policy Number

Previous School Information

<table>
<thead>
<tr>
<th>School - Full Name</th>
<th>Area Code</th>
<th>Phone Number</th>
</tr>
</thead>
</table>

Address

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

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

The grade student was retained/held back
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

<table>
<thead>
<tr>
<th>POLIO 1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEPATITUS B 1</td>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIBS 1</td>
<td></td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>VARICELLA 1 (Chickenpox Vaccine)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please indicate Pass or Fail and the date tested

Hearing Test | Vision Test

Comments:
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

<table>
<thead>
<tr>
<th>CHILD’S NAME (Last, First, Middle)</th>
<th>DATE OF BIRTH (mm/dd/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS (Number &amp; Street) (City) (ZIP Code)</td>
<td>TODAY’S DATE (mm/dd/yy)</td>
</tr>
<tr>
<td>PARENT/GUARDIAN (Last, First, Middle)</td>
<td>HOME TELEPHONE NUMBER</td>
</tr>
<tr>
<td>ADDRESS (Number &amp; Street) (City) (ZIP Code)</td>
<td>WORK TELEPHONE NUMBER</td>
</tr>
</tbody>
</table>

SECTION I - HEALTH HISTORY

<table>
<thead>
<tr>
<th>#</th>
<th>Is your child having any of the problems listed below?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Allergies or Reactions (for example, food, medication or other)</td>
</tr>
<tr>
<td>2</td>
<td>Hay Fever, Asthma, or Wheezing</td>
</tr>
<tr>
<td>3</td>
<td>Eczema or Frequent Skin Rashes</td>
</tr>
<tr>
<td>4</td>
<td>Convulsions/Seizures</td>
</tr>
<tr>
<td>5</td>
<td>Heart Trouble</td>
</tr>
<tr>
<td>6</td>
<td>Diabetes</td>
</tr>
<tr>
<td>7</td>
<td>Frequent Colds, Sore Throats, Earaches (4 or more per year)</td>
</tr>
<tr>
<td>8</td>
<td>Trouble with Passing Urine or Bowel Movements</td>
</tr>
<tr>
<td>9</td>
<td>Shortness of Breath</td>
</tr>
<tr>
<td>10</td>
<td>Speech Problems</td>
</tr>
<tr>
<td>11</td>
<td>Menstrual Problems</td>
</tr>
<tr>
<td>12</td>
<td>Dental Problems: Date of Last Exam</td>
</tr>
<tr>
<td>Other (please describe):</td>
<td></td>
</tr>
</tbody>
</table>

- Does your child take any medication(s) regularly?
  - Reason for Medication
  - Parent/Guardian Signature

Birth History:

Are there any current or past diagnosis(es)?
- Yes
- No

If yes, please describe:

If yes, list medications:

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

<table>
<thead>
<tr>
<th>No</th>
<th>Was child tested for:</th>
<th>Test results:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Normal</td>
</tr>
<tr>
<td></td>
<td>VISION</td>
<td>Visual Acuity</td>
</tr>
<tr>
<td></td>
<td>Date: / /</td>
<td>Other:</td>
</tr>
<tr>
<td></td>
<td>HEARING</td>
<td>Audiometer</td>
</tr>
<tr>
<td></td>
<td>Date: / /</td>
<td>Other:</td>
</tr>
<tr>
<td></td>
<td>URINALYSIS</td>
<td>Sugar</td>
</tr>
<tr>
<td></td>
<td>Date: / /</td>
<td>Microscopic</td>
</tr>
<tr>
<td></td>
<td>BLOOD LEAD LEVEL</td>
<td>Level _____ ug/dl</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>VACCINES (Circle Type)</th>
<th>DATE ADMINISTERED MM/DD/YYYY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hepatitis B</strong></td>
<td>1 3</td>
</tr>
<tr>
<td>(HepB)</td>
<td></td>
</tr>
<tr>
<td><strong>DTaP/DTP/DT/Td</strong></td>
<td>2 5</td>
</tr>
<tr>
<td><strong>Haemophilus Influenza</strong></td>
<td>1 3</td>
</tr>
<tr>
<td>type b (HIB)</td>
<td>2 4</td>
</tr>
<tr>
<td><strong>Polio</strong></td>
<td>1 3</td>
</tr>
<tr>
<td>(IPV/OPV)</td>
<td>2 4</td>
</tr>
<tr>
<td><strong>Pneumococcal Conjugate</strong></td>
<td>1 3</td>
</tr>
<tr>
<td>(PCV7/PCV13)</td>
<td>2 4</td>
</tr>
<tr>
<td><strong>Rotavirus (RV1/RV2)</strong></td>
<td>1 3</td>
</tr>
<tr>
<td><strong>Measles, Mumps, Rubella (MMR)</strong></td>
<td>1 2</td>
</tr>
<tr>
<td><strong>Varicella (Chickenpox)</strong></td>
<td>1 2</td>
</tr>
</tbody>
</table>

**History of Chickenpox Disease?**

- [ ] Yes
- [ ] 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)

- [ ] Is there any defect of vision, hearing or other condition for which the school could help by secluding 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 the 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**

**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 immunization 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.


A.G.B.U. ALEX & MARIE MANOOGIAN SCHOOL  
(EDUCATIONAL FUND)  

CONTRACT FOR PRE-SCHOOL TUITION  
2020-2021 SCHOOL YEAR  

I/We agree to pay the Pre-School tuition fees listed below, as follows:  
Initial payment of $500.00 is due to insure your child’s enrollment.  
Remaining balances are due by the end of each month, September thru May.  

<table>
<thead>
<tr>
<th>STUDENT</th>
<th>GRADE</th>
<th>TUITION FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Registration fee $100.00  

TOTAL  

INITIAL PAYMENT $500.00 Due with contract  

PK3 offered M-W-F  
PK4 offered M-T-W-TH-F  
CIRCLE DAYS TO ATTEND  
M - T - W - TH - F  
Full Day or Half Day  

Enrollment will not be allowed until contract is signed and returned.  
CONTRACT ACCOMPANIED WITH FULL PAYMENT BY JUNE 22, 2020 WILL RECEIVE 15% OFF TUITION  

SIGNED AND ACCEPTED BY  

PARENT/GUARDIAN  

PRINT NAME  

STREET ADDRESS  

CITY  

MI  

ZIP  

DATE  

C.C. ADMINISTRATION  

OFFICE USE ONLY  

Notes to business office:  


A.G.B.U. EDUCATIONAL FUND
248-569-2988

2020-2021 PRE-SCHOOL RATES

TUITION

TWO FULL DAYS  $3500.00  $2975.00
**$345.00 a month (September thru May)

TWO HALF DAYS  $2500.00  $2125.00
**$235.00 a month (September thru May)

THREE FULL DAYS  $4500.00  $382500
**$460.00 a month (September thru May)

THREE HALF DAYS  $3500.00  $2975.00
**$345.00 a month (September thru May)

FOUR FULL DAYS  $5500.00  $4675.00
**$570.00 a month (September thru May)

*FIVE FULL DAYS  $6000.00  $5100.00
**$625.00 a month (September thru May)

Note: $100.00 Registration fee (non-refundable) not included above
$500.00 due with contract

** Price reflects the $500.00 paid at the time of contract
All payments must be received by the end of each month

◊ CONTRACT ACCOMPANIED WITH FULL PAYMENT BY JUNE 22, 2020
WILL RECEIVE 15% OFF TUITION

2-11-2020 – Manoogian School PK3/4