



22001 Northwestern Hwy. ~ Southfield, MI 48075
www.manoogian.org ~ 248-569-2988

A.G.B.U. Alex and Marie Manoogian School
2026-2027
Enrollment Packet

Admission to the Manoogian School will be determined on availability and cannot be included in the lottery process until all the forms are completed and documents listed below are submitted to the office on or before March 27, 2026.

Enrollment application completed, signed, and dated

Transcripts (High School Students ONLY)

Report Card (Most recent)

Original **U.S. Birth Certificate / Passport or Permanent Resident Card** (Green Card)
(Original documents will be returned to parent)

Current Health Appraisal Form – *Due by August 21, 2026*

Immunizations

Hearing - Vision Test – Dental Screening (**Kindergarten**)
completed and **signed and dated by physician**

Please note: Health Appraisal is not due until the student is accepted, but due before the student can start school

Release of Immunization Information form

Record release form

Affirmation of Prior Discipline Record

Proof of Michigan Residency (Driver license/utility bill/lease or rental agreement)

IEP documents if applicable

Applications submitted after March 27, 2026, will be placed on the waiting list for the school year 2026-2027 for any opening. Completed applications are valid for one year only.

Open Enrollment for the 2026-2027 school year
March 3, 2026 – March 27, 2026

ENROLLMENT FORM

Grade Applying For: _____

Last Grade Completed: _____

Last School Attended: _____

REQUIRED DOCUMENTS

CHARTER SCHOOL – KINDERGARTEN – 12TH GRADE

The following documents are required in addition to the completed and signed enrollment form.

Parent Photo ID Original Birth Certificate/Passport Affirmation of Prior Discipline
 Health Appraisal Immunization Record Release of Immunization Information
 Record Release Form Most Recent Report Card & Transcript (High School) Proof of Michigan Residency

STUDENT INFORMATION

First Name:		Middle Name:	Last Name:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: (MM/DD/YYYY)	Birthplace: (City/State/Country)	If born in any country other than U.S.A. What year did the student arrive in the U.S.A.? _____ Year
Student Cell Number:	Student Email:	When did the student first enroll in a U.S school? _____ MM/DD/YYYY	
Siblings currently enrolled at Manoogian:			

STUDENT ETHNICITY

Student's Race (select all that apply)

- American Indian Asian Black or African American Hispanic or Latino
 Native Hawaiian/Other Pacific Islander White (Armenian/European/Middle Eastern/North African)

STUDENT'S ADDRESS

Street:	Apt #:
City:	State:
	ZIP Code:

HOME LANGUAGE SURVEY

Michigan welcomes families of all language backgrounds. Speaking more than one language is a valuable asset!

Please answer the two questions below. If your response to either question is a language other than English, the school district will give an assessment to see if your student may benefit from English language support.

What language is used most at home? _____ What language is used most by the student? _____

SPEECH/SPECIAL EDUCATION SERVICES

- Did this child ever receive Special Education services (IEP) or if ever was on a 504? Yes No
- Does this child have an active Individualized Education Plan (IEP)? Yes No (If you answered yes please answer following questions)
- Speech/Language services received at previous school? Yes No
- Special Education services received at previous school? Yes No

If you answered "yes" to any of the above, please provide a copy of your special education documents (IEP/504) with your enrollment packet.

PUBLICATIONS/MEDIA CONSENT AND RELEASE DATA

Military Use - exclude student information from being sent to military recruiters. Yes No

Public Use - exclude student information from being sent outside the school district (such as newspapers, television, radio, school website, social media, displays, brochures, and other types of media). This does not have anything to do with articles and photos to be used in the yearbook. Yes No

Higher Ed Use - exclude student information from being sent to institutions of higher education (colleges). Yes No

INFORMATION OF PARENT/GUARDIAN 1

Title:	First Name:	Last Name:		
Date of Birth: (MM/DD/YYYY)	Relationship to student:		Email Address:	
Primary / Home Phone		Cell Phone		Work Phone
Same address as student's address? <input type="checkbox"/> Yes <input type="checkbox"/> No, provide address				
Street:				Apt #:
City:		State:	ZIP Code:	
Does the parent/guardian require communication from the school in a language other than English? <input type="checkbox"/> No <input type="checkbox"/> Yes, what language? _____				

INFORMATION OF PARENT/GUARDIAN 2

Title:	First Name:	Last Name:		
Date of Birth: (MM/DD/YYYY)	Relationship to student:		Email Address:	
Primary / Home Phone		Cell Phone		Work Phone
Same address as student's address? <input type="checkbox"/> Yes <input type="checkbox"/> No, provide address				
Street:				Apt #:
City:		State:	ZIP Code:	
Does the parent/guardian require communication from the school in a language other than English? <input type="checkbox"/> No <input type="checkbox"/> Yes, what language? _____				

INFORMATION OF PARENT/GUARDIAN 3

Title:	First Name:	Last Name:		
Date of Birth: (MM/DD/YYYY)	Relationship to student:		Email Address:	
Primary / Home Phone		Cell Phone		Work Phone
Same address as student's address? <input type="checkbox"/> Yes <input type="checkbox"/> No, provide address				
Street:				Apt #:
City:		State:	ZIP Code:	
Does the parent/guardian require communication from the school in a language other than English? <input type="checkbox"/> No <input type="checkbox"/> Yes, what language? _____				

EMERGENCY INFORMATION

First and Last Name of Physician:	Phone number:
Preferred Hospital:	City where hospital is located:
Family Insurance Provider:	Insurance Policy Number:

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 school database:

EMERGENCY CONTACTS

First and Last Name:	Telephone Number:	Relationship to student:
First and Last Name:	Telephone Number:	Relationship to student:
First and Last Name:	Telephone Number:	Relationship to student:

PREVIOUS SCHOOL INFORMATION

School Name:	School Phone Number:
School Address, City, State, ZIP Code:	
Has this student ever been retained/held back? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Has this student ever been expelled or suspended from another school? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, please explain:	

As the parent/legal guardian, I affirm all information provided with this form is true and accurate, and that my child and I reside at the listed address. The undersigned understands that 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 office 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 reside 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 & 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.

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Parent Signature:

Date:

RELEASE OF IMMUNIZATION INFORMATION

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 States and Local health departments must monitor immunizations 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.

Release of Immunization Information

With the start of the 2026-2027 school year, schools are required to obtain permission from parents to make immunization information available for viewing by the state and local Health Departments. All students in both kindergarten and seventh grade, as well as newly enrolled students to the district, are required to be placed on the state immunization registry.

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: _____ Date: _____

Printed Parent/Guardian Name: _____

AFFIRMATION OF PRIOR DISCIPLINE RECORD



AGBU Alex & Marie
MANOOGIAN
SCHOOL
Heritage • Achievement • Excellence

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, 22001 Northwestern Hwy., Southfield, MI 48075.

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's 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's 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

Information below will be filled out by previous school district

Name of previous school district: _____

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: _____

MDHHS-3305, HEALTH APPRAISAL

Michigan Department of Health and Human Services (MDHHS)

(Revised 7-24)

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 1. Section 4 may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse, dentist, dental therapist, and dental hygienist.

(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION).

SECTION 1 – PERSONAL

Child's Name (Last, First, Middle)	Date of Birth (mm/dd/yy)
Address (Number, Street, City, Zip Code)	Today's Date (mm/dd/yy)
Parent/Guardian (Last, First, Middle)	Home/Cell Phone Number
Address (Number, Street, City, Zip Code)	Work Phone Number

SECTION 2 – HEALTH HISTORY

Yes	No	Resolved	Is your child having any of the problems listed below?	Birth History
<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. Anaphylaxis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Does your child take any medication(s) regularly?	If yes, list medications
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Hay Fever, Asthma, or Wheezing	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Eczema or Frequent Skin Rashes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Convulsions/Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Heart Trouble	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Frequent Colds, Sore Throats, Earaches (4 or more per year)	Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Trouble with Passing Urine or Bowel Movements	If yes, describe
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Shortness of Breath	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Speech Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Menstrual Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Dental Problems Date of Last Exam OR Date of Last Assessment	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Other (describe)	

Reason for Medication

Concussion History

Parent/Guardian Signature

Date

Was the health history reviewed by a health professional?

Examiner's Initials

Yes No

SECTION 3 - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Test and Measurements

Yes	No	Was child test for	Tests and results	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	Vision	Visual Acuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Date	Muscle Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hearing	<input type="checkbox"/> Audiometer (R= Right, L=Left)			
		Date	<input type="checkbox"/> OAE (R= Right, L=Left)			
			<input type="checkbox"/> Other (R= Right, L=Left)			
<input type="checkbox"/>	<input type="checkbox"/>	Urinalysis	Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Albumin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Microscopic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Blood Lead Level	Level ug/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Date				

Note: All children in Medicaid need to be tested at 1 and 2 years of age, or once between 3 and 6 years of age if not previously tested. All children, regardless of Medicaid status, should be tested at those same ages if they live in an area where lead risk is high.

<input type="checkbox"/>	<input type="checkbox"/>	Height & Weight	Height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hemoglobin/Hematocrit	⇒	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure	Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Complete pediatric tuberculosis risk assessment available at:

https://www.michigan.gov/documents/mdhhs/4_MI_Pediatric_TB_Risk_Assessment_661537_7.pdf OR feel free to use the attached QR code instead of the full link text.



Examinations and/or Inspections

Essential Findings Deviating from Normal

Exam Date

SECTION 4 – IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied based on this information.*

Vaccines (Select Type)	Date Administered (mm/dd/yy)		
Hepatitis B (HepB)	1.	2.	3.
	4.		
DTaP/DTP/DT/Td	1.	2.	3.
	4.	5.	6.
Tdap	1.		
<i>Haemophilus Influenzae</i> type b (HIB)	1.	2.	3.
	4.		
Polio (IPV/OPV)	1.	2.	3.
	4.	5.	
Pneumococcal Conjugate (PCV)	1.	2.	3.
	4.		
Rotavirus (RV1/RV5)	1.	2.	3.
Measles, Mumps, Rubella (MMR/MMRV)	1.	2.	3.
Varicella (Chickenpox), (Var, MMRV)	1.	2.	
Hepatitis A (HepA)	1.	2.	3.

Influenza (IIV/LAIV)	1 .	2 .	3 .
	4 .		
Meningococcal (MCV4, MenABCWY)	1 .	2 .	3 .
Meningococcal B (Bexsero, Trumenba, MenABCWY)	1 .	2 .	3 .
Human Papillomavirus (HPV)	1 .	2 .	3 .

Additional 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.

History of Chickenpox Disease?

If yes, date

Yes No

Parent/Guardian refused recommended immunizations at visit.

I certify that the immunization dates are true to the best of my knowledge

Health Professional Signature

Title

Date

SECTION 5 - 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 seating or other actions?

Yes No

If yes, explain

Should the child's activity be restricted because of any physical defect or illness?

Yes No

Check all that apply

Classroom

Playground

Gymnasium

Swimming Pool

Competitive Sports

Other

If yes, explain degree of restriction(s)

Other Recommendations

SECTION 6 - DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS

Child's Name	Type of Service
	<input type="checkbox"/> Dental Exam <input type="checkbox"/> Dental Assessment
Findings (Check all that apply)	
<input type="checkbox"/> No findings <input type="checkbox"/> Treated Decay <input type="checkbox"/> Untreated Decay	
Recommendations (Check one)	
<input type="checkbox"/> Routine Care	
<input type="checkbox"/> Referral for dental treatment	
<input type="checkbox"/> Referral for urgent dental care	
Provider Signature	Date
Check one	
<input type="checkbox"/> Dentist <input type="checkbox"/> Dental Therapist <input type="checkbox"/> Dental Hygienist	

SECTION 7 - PHYSICIAN'S SIGNATURE

Examiner's Name (Print)	Degree or License	Telephone Number
Examiner's Signature	Date	
Address	City	State Zip Code
		MI

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 preventative and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-childcare 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.

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.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.