

# Mount Clemens Montessori Academy Student Enrollment Form

## 2024-2025

### STUDENT BASIC INFORMATION

Student's Last Name:		Grade for 2024-2025 School Year Please Circle: Y5 K 01 02 03 04 05
Student's First Name:		Middle Initial:
Student's Date of Birth: (Provide Birth Certificate)	___/___/___	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian Name:		Phone:
		Email:
Parent/Guardian Name:		Phone:
		Email:

Student Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Is the student's parent or guardian currently on active duty for any branch of the military?  
 Yes  
 No      If so, which branch: \_\_\_\_\_

<i>Both parts must be completed. If either part is not answered, the U.S. Department of Education requires the Academy to supply an answer on your behalf.</i>	Is your child Hispanic/Latino? (Choose only one) <input type="checkbox"/> Yes <input type="checkbox"/> No	What is the race of the child? (Choose one or more boxes) <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White
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<i>The following information is not required; however, it will be used to determine whether the school is eligible for supplemental funding to enhance instructional opportunities for immigrant children and youth.</i>	Is your child between the ages of 3 and 21?  <input type="checkbox"/> Yes <input type="checkbox"/> No	Was your child born outside of the United States? ("United States" is defined as the 50 states, the District of Columbia and the Commonwealth of Puerto Rico) <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your child attended one or more schools in the United States for less than three full academic years?  <input type="checkbox"/> Yes <input type="checkbox"/> No
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<i>The following information is not required; however, it is necessary to determine if your child is eligible for English Language Support.</i>	Is your child's native tongue a language other than English? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the language? _____	What is the primary language spoken in your home? <input type="checkbox"/> English <input type="checkbox"/> Other: _____
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### EMERGENCY CONTACT INFORMATION (non-custodial)

Emergency Contact #1	Name:	Relationship:
	Home Phone:	Cell Phone:
	Work Phone:	Email:
Emergency Contact #2	Name:	Relationship:
	Home Phone:	Cell Phone:
	Work Phone:	Email:
Emergency Contact #3	Name:	Relationship:
	Home Phone:	Cell Phone:
	Work Phone:	Email:

Legally, do not release my child to: \_\_\_\_\_. The Academy will not comply with your request until receipt of Personal Protection Order and/or Custody Papers.

## MEDICAL INFORMATION

List severe allergies:  
(i.e., peanut allergy, etc.)

List medical concerns which require a medical action plan: (Chronic health concerns such as diabetes, asthma, epilepsy, etc.)

List medications/treatments:

Doctor's Name:

Phone:

### SPECIAL SERVICES (Please check all that apply)

Student has previously received special services?  Yes  No  I do not know

#### Support Services:

- 504 Plan
- Speech Therapy
- Occupational Therapy
- Physical Therapy
- Social Work
- Assistive Technology \_\_\_\_\_
- English Language Support
- Title IA/31a Services
- Other: \_\_\_\_\_

#### Special Education:

- Specific Learning Disability
- Emotional Impairment
- Cognitive Impairment
- Physical Impairment
- Other Health Impairment
- Autism Spectrum Disorder
- Visual Impairment
- Deaf Blindness
- Hearing Impairment
- Early Childhood Developmental Delay
- Speech and Language Impairment
- Severe Multiple Impairment
- Traumatic Brain Injury
- Other: \_\_\_\_\_

#### Service Delivery:

- Self-contained classroom
- Resource Room
- Co-taught courses
- TC support only
- Date of last IEP: \_\_\_\_\_
- Date of last REED: \_\_\_\_\_

#### **FOR OFFICE USE ONLY (Initial complete, NA if not applicable)**

- \_\_\_\_ Health Appraisal
- \_\_\_\_ Immunizations Record or Waiver
- \_\_\_\_ Birth Certificate (copy)
- \_\_\_\_ Driver's License (copy)
- \_\_\_\_ Student Records Request Form (New Students Only)
- \_\_\_\_ Student Residency Questionnaire
- \_\_\_\_ IEP (If Applicable)
- \_\_\_\_ Free & Reduced Meals Application (Sent Home in September)
- \_\_\_\_ Household Information Report (Sent Home in September)

#### \_\_\_\_ Permission Statements Form

- Photograph & Publicity Release Form
- Network & Internet Acceptable Use Agreement
- Authorization for Administering Medication/Treatment
- Handbook Acknowledgement
- \_\_\_\_ Directory Information Opt-out Form
- \_\_\_\_ Concussion Information Acknowledgement
- \_\_\_\_ PPO/Custody Papers/Other Court Documents (If Applicable)
- \_\_\_\_ Medical Action Plan (If Applicable)

I affirm that all the information provided is complete and accurate to the best of my knowledge:

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



## PERMISSION STATEMENTS

### PHOTO / VIDEO RELEASE

Mt. Clemens Montessori Academy, CS Partners and its agents have my permission to use my and or my child(ren)'s name, likeness, image, voice, and/or appearance as such may be embodied in any pictures, photos, video recordings, audiotapes, digital images, and the like, taken or made on behalf of the Academy. I agree that the Academy and CS Partners may have complete ownership of such pictures, etc., including the entire copyright, and may use them for any purpose consistent with the Academy's mission. These uses include, but are not limited to, illustrations, bulletins exhibitions, videotapes, reprints, reproductions, publications, advertisements, and any promotional or other materials in any medium now known or later developed, including the Internet. I acknowledge that I will not receive any compensation, etc. for the use of such pictures, etc., and hereby release the Academy and its agents and assigns from any and all claims which arise out of or are in any way connected with such use.

I have read and understood this consent and release.

***I give my consent*** to the Academy and CS Partners to use my and or my child(ren)'s name and likeness as described above.

\_\_\_\_\_  
Parent/Legal Guardian

\_\_\_\_\_  
Date

***I do not give my consent*** to the Academy and CS Partners to use my and or my child(ren)'s name and likeness as described above.

\_\_\_\_\_  
Parent/Legal Guardian

\_\_\_\_\_  
Date

Checking this box indicates that you also do not want your child's picture in the yearbook.

### LAWN SIGNS (please check one)

- I give my permission for Mt. Clemens Montessori Academy to put a "Welcome to Mt. Clemens Montessori Academy" sign on my lawn.
- I do not give my permission for Mt. Clemens Montessori Academy to put a "Welcome to Mt. Clemens Montessori Academy" sign on my lawn.

**NETWORK AND INTERNET ACCEPTABLE USE POLICY** I have read the Network and Internet Acceptable Use Agreement (NIAUA) available at the school and on our website. I grant permission for my child to access network computer services and Internet resources. I agree to comply with the NIAUA. If you do not want your child to use the Internet, please contact the Office.

**Directory Opt-Out Form**

I have read and reviewed the Directory Opt-Out Form on the website I understand that the Family Educational Rights and Privacy Act (FERPA), a federal law, allows the Academy/Authorizer to disclose designated "directory information" to third parties without my written consent, unless I inform the Academy/Authorizer otherwise. "Directory information" is information that is generally not considered harmful or an invasion of privacy if released. The Directory Opt-Out form only needs to be returned to the Academy if I wish to opt-out of any directory information.

**PERMISSION TO WALK AND RELEASE TO CAR**

I understand that all students go on walks in the school neighborhood throughout the school year. If I do not want my child to go on walks, I will contact the Office. I understand that students are released at the door and walk to awaiting cars. I assume full responsibility for my child after he/she leaves the school entrance each day.

**PHYSICAL HEALTH/IMMUNIZATIONS PARENTAL ACKNOWLEDGEMENT**

My child is in good health and his/her immunizations are current. I understand that I assume responsibility for my child's health while attending Mt. Clemens Montessori Academy. I have noted any health restrictions/needs, allergies, and medications taken by my child in the health section of this application.

**PARENT NOTIFICATION OF THE LICENSING NOTEBOOK REQUIREMENT**

I am aware that all childcare centers must maintain a licensing notebook which includes all licensing inspection reports, special investigation reports, and all related corrective action plans (CAP). The notebook must include all reports issued and CAPs developed on and after May 27, 2010 until the license is closed. This center maintains a licensing notebook of all licensing inspection reports, special investigation reports and all related corrective action plans. The notebook will be available to parents for review during regular business hours. Licensing inspection and special investigation reports from the past two years are available on the Bureau of Children and adult Licensing website at [www.michigan.gov/michildcare](http://www.michigan.gov/michildcare).

**PARENT/STUDENT HANDBOOK ACKNOWLEDGEMENT**

I have received or viewed the Mt. Clemens Montessori Academy Parent-Student Handbook at [www.mtclemensmontessori.com](http://www.mtclemensmontessori.com). I agree to abide by the policies and procedures contained therein. I understand that the policies contained in the handbook may be added to, deleted, or changed at any time.

**I certify that the information on this form is true and correct to the best of my knowledge.**

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Parent/Guardian Signature

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Date

## STUDENT RESIDENCY

This questionnaire is intended to address the McKinney-Vento Act, in regards to children and youth in transitional living arrangements. Your answer will help the administration determine residency documents necessary for enrollment and additional services available to your family. This questionnaire will be kept separately from the student's permanent record and filed by the Homeless Education Liaison.

1. Where is the student living now? (check one box)

- in a shelter or temporary housing
- in a motel or hotel
- with more than one family in a house or apartment
- in a car
- in a trailer on a campsite
- with friends or family member (other than parent/guardian)
- Other, please explain: \_\_\_\_\_
  
- none of the above (please sign form)

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

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

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

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

**If you marked "none of the above" you do not have to complete the remainder of this form.**

2. Does the living arrangement checked in Question 1 result from a loss of housing or economic hardship?  
 yes       no       unsure

If you answered "yes" to the above question, do you consider yourself to be homeless?

yes       no

3. The student lives with

- 1 parent
- 2 parents
- 1 parent & another adult
- a relative, friend(s), or other adults
- alone with no adults
- an adult who is not the parent or legal guardian

4. If you are living in shared housing, please check all of the following reasons that apply:

- \_\_\_\_\_ Loss of housing
- \_\_\_\_\_ Economic situation
- \_\_\_\_\_ Temporarily waiting for house or apartment
- \_\_\_\_\_ Provide care for a family member
- \_\_\_\_\_ Living with boyfriend/girlfriend
- \_\_\_\_\_ Loss of employment
- \_\_\_\_\_ Parent/Guardian is deployed
- \_\_\_\_\_ Other (Please explain)

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



A Better School of Thought.

1st request \_\_\_\_\_ Faxed/Mailed
2nd request \_\_\_\_\_ Faxed/Mailed
3rd request \_\_\_\_\_ Faxed/Mailed

AUTHORIZATION FOR REQUEST/RELEASE OF STUDENT RECORDS

This authorizes a one-time only release to the above organizations and/or individuals

To Release:

- All records-- UIC number (Michigan Schools only) (including 504 Plan, discipline, psychological and special education testing information - IEP & MET)
Transcript of student's record, including key to grading system, Grades at time of release, Standardized Test Data, Health Records

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

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

Has student ever been suspended? Yes [ ] No [ ] Has student ever been expelled? Yes [ ] No [ ]

Explain: \_\_\_\_\_

I authorize (Former School District): \_\_\_\_\_

Name of School Student Attended \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

PLEASE SEND CA-60 STUDENT RECORDS and SPECIAL EDUCATION RECORDS TO:

Mt. Clemens Montessori Academy
1070 Hampton Rd.
Mt. Clemens, MI 48043
Fax: 586-465-2283

Signed \_\_\_\_\_

Parent/Legal Guardian Printed Name

Date

Sending School only:

Name of Sending (former) school: \_\_\_\_\_

- According to our records, we can verify that the information provided above by the parent is correct.
According to our records, the information provided above by the parent is not correct.

Date

Signature of sending School District Administrator & Title

Telephone number

# 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?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)	<b>Birth History:</b>  Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:  If yes, list medications:  Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Examiner's Initials:</b> _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2 Hay Fever, Asthma, or Wheezing	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3 Eczema or Frequent Skin Rashes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4 Convulsions/Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 Heart Trouble	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6 Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8 Trouble with Passing Urine or Bowel Movements	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9 Shortness of Breath	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10 Speech Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11 Menstrual Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12 Dental Problems: Date of Last Exam / /	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe): _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child take any medication(s) regularly?	
			Reason for Medication	⇒
			_____ / _____ / _____	
			<b>Parent/Guardian Signature</b> _____ Date	

## 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	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	VISION Date: ___/___/___	Visual Acuity Muscle Imbalance Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT Other: _____	Height Weight Other: _____			
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: ___/___/___	Audiometer Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE	⇒ Reading: _____			
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: ___/___/___	Sugar Albumin Microscopic				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN Date: ___/___/___	Type: _____ Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm			
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: ___/___/___	Level _____ ug/dl	⇒									

**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: ___/___/___





# Child History

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

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

Occupation: \_\_\_\_\_ Occupation: \_\_\_\_\_

Conditions at Birth: \_\_\_\_\_

Is Child adopted? \_\_\_\_\_

Ages for the following: Crawling \_\_\_\_\_ Creeping \_\_\_\_\_ Standing \_\_\_\_\_

Walking \_\_\_\_\_ Talking in Words \_\_\_\_\_

Any speech deviations? \_\_\_\_\_

History of illnesses? \_\_\_\_\_

Does your child have any special physical, emotional, or learning problems? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Did your child have difficulties with toilet training? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Is either parent deceased or absent for long periods? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Number of children in the family? \_\_\_\_\_ Does child get along with siblings? \_\_\_\_\_

For child's age, is he/she independent/dependent? \_\_\_\_\_

What are child's eating habits? \_\_\_\_\_

Is child cared for by anyone other than parents? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

How long have you lived in your present neighborhood? \_\_\_\_\_

Are there children in the neighborhood with whom your child plays? \_\_\_\_\_

Does your child play alone or with others? \_\_\_\_\_

With what age children does your child usually play? \_\_\_\_\_

Does your child seek adult attention? \_\_\_\_\_

If yes, whose attention? \_\_\_\_\_

By what means? \_\_\_\_\_

Does your child accept new people easily? \_\_\_\_\_

Does your child have any special fears? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Please check your child's previous experiences with other children:

Neighborhood Play: \_\_\_\_\_ Daycare: \_\_\_\_\_ Nursery School: \_\_\_\_\_

Summer Camp: \_\_\_\_\_ Sunday School: \_\_\_\_\_ Other experiences: \_\_\_\_\_

Why do you wish to send your child to a Montessori School? \_\_\_\_\_

Does your child have any specific responsibilities at home? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Does your child participate in any outside school activities? \_\_\_\_\_

Does your child have a regular scheduled time for meals and bedtime? \_\_\_\_\_

When you find it necessary to discipline your child, what do you usually do?

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

# Mt. Clemens Montessori Academy

## Educational Material for Parents and Students (Content Meets MDCH Requirements)

Sources: Michigan Department of Community Health, CDC and the National Operating Committee on Standards for Athletic Equipment (NOCSAE)

### UNDERSTANDING CONCUSSION

#### Some Common Symptoms

Headache	Balance Problems	Sensitive to Noise	Poor Concentration	Not "Feeling Right"
Pressure in the Head	Double Vision	Sluggishness	Memory Problems	Feeling Irritable
Nausea/Vomiting	Blurry Vision	Haziness	Confusion	Slow Reaction Time
Dizziness	Sensitive to Light	Fogginess	"Feeling Down"	Sleep Problems
		Grogginess		

#### WHAT IS A CONCUSSION?

A **concussion is a type of traumatic brain injury** that changes the way the brain normally works. A concussion is caused by a fall, bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. A concussion can be caused by a shaking, spinning or a sudden stopping and starting of the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious. A concussion can happen even if you haven't been knocked out.

You can't see a concussion. Signs and symptoms of concussions can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If the student reports any symptoms of a concussion, or if you notice symptoms yourself, seek medical attention right away. A student who may have had a concussion should not return to play on the day of the injury and until a health care professional says they are okay to return to play.

#### IF YOU SUSPECT A CONCUSSION:

- SEEK MEDICAL ATTENTION RIGHT AWAY** – A health care professional will be able to decide how serious the concussion is and when it is safe for the student to return to regular activities, including sports. Don't hide it, report it. Ignoring symptoms and trying to "tough it out" often makes it worse.
- KEEP YOUR STUDENT OUT OF PLAY** – Concussions take time to heal. Don't let the student return to play the day of injury and until a health care professional says it's okay. A student who returns to play too soon, while the brain is still healing, risks a greater chance of having a second concussion. Young children and teens are more likely to get a concussion and take longer to recover than adults. Repeat or second concussions increase the time it takes to recover and can be very serious. They can cause permanent brain damage, affecting the student for a lifetime. They can be fatal. It is better to miss one game than the whole season.
- TELL THE SCHOOL ABOUT ANY PREVIOUS CONCUSSION** – Schools should know if a student had a previous concussion. A student's school may not know about a concussion received in another sport or activity unless you notify them.

#### SIGNS OBSERVED BY PARENTS:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Can't recall events prior to or after a hit or fall
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes

#### CONCUSSION DANGER SIGNS:

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. A student should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people/places
- Becomes increasingly confused, restless or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously.)

#### HOW TO RESPOND TO A REPORT OF A CONCUSSION:

If a student reports one or more symptoms of a concussion after a bump, blow, or jolt to the head or body, he/she should be kept out of athletic play the day of the injury. The student should only return to play with permission from a health care professional experienced in evaluating for concussion. During recovery, rest is key. Exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse. Students who return to school after a concussion may need to spend fewer hours at school, take rests breaks, be given extra help and time, spend less time reading, writing or on a computer. After a concussion, returning to sports and school is a gradual process that should be monitored by a health care professional.

Remember: Concussion affects people differently. While most students with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer. To learn more, go to [www.cdc.gov/concussion](http://www.cdc.gov/concussion).

**Parents and Students Must Sign and Return the Educational Material Acknowledgement Form**

# Mt. Clemens Montessori Academy

## CONCUSSION AWARENESS

### EDUCATIONAL MATERIAL ACKNOWLEDGEMENT FORM

By my name and signature below, I acknowledge in accordance with Public Acts 342 and 343 of 2012 that I have received and reviewed the Concussion Fact Sheet for Parents and/or the Concussion Fact Sheet for Students provided by **Mt. Clemens Montessori Academy.**

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Participant Name Printed

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Participant Signature

---

Date

---

Parent or Guardian Name Printed

---

Parent or Guardian Signature

---

Date

Return this signed form to the sponsoring organization that must keep on file for the duration of participation or age 18.

Participants and parents please review and keep the educational materials available for future reference.

# Mt. Clemens Montessori Academy

## Volunteer Form

*(Optional)*

*Please fill out if you would like to be considered for chaperoning field trips or assisting in the classroom*

**Volunteer Information:**

<i>Student's Name</i>
-----------------------

**Volunteer Information:**

<i>Last Name</i>	<i>First Name</i>	<i>Middle Initial</i>	
<i>Street Address</i>		<i>City</i>	<i>Zip Code</i>
<i>Email Address</i>			
<i>Home Phone</i>		<i>Cell Phone</i>	
<i>Date of Birth</i>		<i>Race</i>	<i>Male / Female</i>
<i>Parent / Guardian / Other:</i>		<i>Student's Name</i>	
<i>MI Driver's License Number</i>			<i>Date of Expiration</i>
<i>Any other last names used:</i>		<i>Any other first names used:</i>	

Please check one:

- \_\_\_\_\_ 1. I have not been convicted, pled guilty, or nolo contendere (no contest) to any crimes.
- \_\_\_\_\_ 2. I have been convicted, pled guilty, or nolo contendere (no contest) to the following crimes:  
(use separate sheet to explain nature of conviction, date and court)
- a. \_\_\_\_\_
- b. \_\_\_\_\_

**Certification of Policy & Authorization:**

I understand and agree that Mt. Clemens Montessori Academy will be requesting a criminal history background check on my behalf from the Internet Criminal History Access Tool (ICHAT). As a chaperone, I will not purchase any items for any students during field trips.

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