



# THREE LAKES ACADEMY

W17540 Main Street

P.O. Box 159

Curtis, MI 49820

*"Inspiring a Life Long  
Love for Learning"*

www.threelakesacademy.com

Phone: 906-586-6631

Rachel Bommarito, Administrator

Fax: 906-586-6573

Janet Linck, Business Mgr.

## CONSENT TO RELEASE CONFIDENTIAL INFORMATION

TO: \_\_\_\_\_

Entity name

RE: \_\_\_\_\_

Child's name

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

I, \_\_\_\_\_, (Parent / Guardian) authorize you to disclose to Three Lakes Academy or any representative of Three Lakes Academy, any and all past, present, and future records, reports, or other information you have on file concerning my above-named child, including confidential and cumulative educational records, testing records, psychological or psychiatric reports, evaluations of any sort, and any other records that are requested by Three Lakes Academy for the purpose of representing my interests with regard to my child's education.

I understand my consent is revocable, except to the extent that action has already been taken; otherwise, this Consent remains in effect for one year, or until I revoke it, whichever occurs first. You are authorized and requested to accept this authorization, whether it bears an original or Photostatic copy of my signature.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature



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## Applicant Information:

Please Print

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Telephone: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

O Male O Female DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security# \_\_\_\_\_

-Must Provide Birth Certificate-

-Must Provide Original Card

### Ethnicity:

African American (Non-Hispanic)

Hispanic or Latino

White (Non-Hispanic)

American Indian/Alaskan Native

Asian American

Native Hawaiian or Other Pacific Islander

Was your child receiving Special Education Services?

No

Yes

If yes, do you have your child's special education records (IEP)?

No

Yes

If yes, please attach a copy.

### Child lives with:

Both Parents

Mother only

Father only

Legal Guardian

Other Relative (please state relationship) \_\_\_\_\_

Both Parents Alternately (If both parents, please indicate Custodial Parent)

Custodial Parent's Name \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Cell Telephone: \_\_\_\_\_



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## Parent/Guardian Information

Mother: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Home Telephone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
 Business Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Business Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Father: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Home Telephone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
 Business Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Business Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

(If the student is living with Guardian(s), complete this section)

Guardian: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Home Telephone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
 Business Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Business Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Telephone \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

In the event emergency medical treatment is required, I give consent for my child(ren) to be transferred the nearest medical facility and if necessary to be treated by a qualified physician. THREE LAKES ACADEMY will not transport my child(ren) to the nearest medical facility. If my designated emergency contact or I are not available, THREE LAKES ACADEMY will telephone 911 for emergency assistance.

Parent/Legal Guardian Signature

Date



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## School Messaging System Consent Form

Dear Parents/Guardians,

The Federal Communications Commission now requires consent to receive automated calls/text messages.

**\*\*Please fill out and return this form to ensure you receive informational calls\*\*.**

Three Lakes Academy utilizes the School Messenger notification service to send you phone and text messages to provide you with important information about school events and/or emergencies. We will utilize School Messenger to notify you of school delays or cancellations due to inclement weather, as well as remind you about various events, including report card distribution, field trips, and school functions.

Student Name(s) (Please Print): \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian Name of Student (Please Print): \_\_\_\_\_

I would prefer to be contacted via (Please check all that apply):

- Automated phone call      Number: \_\_\_\_\_
- Automated text message      Number: \_\_\_\_\_
- Automated e-mail      E-mail Address \_\_\_\_\_

Note: By providing a Primary phone number, you are giving permission to Three Lakes Academy to send automated phone calls to your phone.

By signing this form, you are authorizing Three Lakes Academy to use an automated system to periodically deliver automated informational calls or text messages to the phone number(s) provided above. Standard message & data rates may apply. If you change your phone number or no longer want to receive automated calls or texts, you agree to inform Three Lakes Academy immediately. I agree that this consent will remain valid and I will continue to receive automated phone calls until I revoke my consent.

Parent/Guardian/Staff Signature: \_\_\_\_\_

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

THREE LAKES ACADEMY

BUSING INFORMATION

STUDENT NAME: \_\_\_\_\_

PICKUP & TAKE HOME INFORMATION:

Please state and describe the exact location your child will be picked up and dropped off.

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

Description: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

An Emergency Phone Number and/or Drop Off Place in Case of an Early Dismissal or  
Emergency:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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## **Volunteer Code of Confidentiality**

**Three Lakes Academy is committed to maintain the security and confidentiality of all students and information. Selected volunteers with access to student records or information must adhere to the Volunteer Code of Confidentiality as outlined in the guidelines below. Violations of these guidelines may result in a reassignment and/or restriction of the volunteer's responsibilities by the administrator or designee.**

**All student records should be considered confidential.**

**Directory information, including student's name, address, telephone number, date and place of birth, students photograph, major field of study, participation in officially recognized activities and sports, weight of members of athletic teams, dates of attendance, degrees and awards received and previous agencies or institutions, can be shared with administrative approval.**

**Records should not be left in a place where they can be viewed by others.**

**Copies of records can only be shared with administrative approval.**

**Volunteers should not discuss or repeat information while in the staff lounge, classrooms, offices, school grounds, hallways, school or extra curricular activities.**

**Volunteers should not discuss information obtained while in a classroom, such as a student's grade of behavior, with anyone other than the student's teacher.**

**Concerns or questions regarding student records or issues of confidentiality should be brought to the attention of the staff member that supervises the volunteer, and/or school administrator.**

**Any knowledge of a violation of this Code of Confidentiality should be immediately reported to the staff member that supervises the volunteer, and/or school administrator.**

**By signing, I acknowledge that I have read, understand, and will comply with the Volunteer Code of Confidentiality.**

\_\_\_\_\_  
**Volunteer Signature**

\_\_\_\_\_  
**Date**



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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 the 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 Three Lakes Academy to release my child's immunization records 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: \_\_\_\_\_

## 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.*

Name of Student: \_\_\_\_\_ Name of School: \_\_\_\_\_

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

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 relationship to the 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: \_\_\_\_\_  
The undersigned certifies that the information provided is accurate.

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

COPIES TO:

School Use Only

- |                           |                      |
|---------------------------|----------------------|
| 1. District Liaison       | 5. Food Services     |
| 2. MSDS Data Person       | 6. CA 60             |
| 3. Building Administrator | 7. Classroom Teacher |
| 4. School Counselor       |                      |



School District Name

# Household Information Report

SCHOOL USE

ONLY

Address

for:

Address

Phone

Email

Approved

1  2

To determine eligibility for various additional state and federal program benefits that your school may qualify for, please complete, sign and return this report to \_\_\_\_\_.

(School Name)

**These sections must be completed by the head of household or designee.**

**PART A. SIZE OF FAMILY** - Enter the total number of individuals living in your household, including all adults and children → \_\_\_\_\_

**PART B. CURRENT BENEFITS** - Complete below if applicable

If any member of your household receives Food Assistance Program (FAP), Family Independence Program (FIP), or FDPIR, provide the name and case number for the person who receives benefits. Bridge Card Numbers and Medicaid Numbers are NOT ACCEPTABLE case numbers.

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

Case Number: \_\_\_\_\_

**PART C. STUDENT INFORMATION** – Complete for each student Pre-K through 12th Grade

| Last Name | First Name | Birth Date<br>XX-XX-XXXX | School | Identify<br>H if Homeless<br>M if Migrant<br>R if Runaway<br>F if Foster |
|-----------|------------|--------------------------|--------|--|
|           |            |                          |        |  |
|           |            |                          |        |  |
|           |            |                          |        |  |
|           |            |                          |        |  |
|           |            |                          |        |  |
|           |            |                          |        |  |

If you need additional lines, attach a second sheet to this report or attach a copy of this report clearly marked as a **Page 2**.

**PART D. TOTAL MONTHLY HOUSEHOLD INCOME** – Report income for all members of household excluding Foster Children. If you have reported a case number above, you do not need to fill in this section. Simply sign and date form.

| Type of Income  | Income | Circle if None |
|---|--------|----------------|
| 1. Gross Monthly Earnings: Wages, Salary, Commissions           | \$     | None           |
| 2. Monthly Welfare Payments, Child Support, Alimony             | \$     | None           |
| 3. Monthly Payments from Pensions, Retirement, Social Security  | \$     | None           |
| 4. Monthly Dividends or Interest on Savings                     | \$     | None           |
| 5. Monthly Worker's Compensation, Unemployment, Strike Benefits | \$     | None           |
| 6. Other Monthly Income (SSI, VA, Disability, Farm, other)      | \$     | None           |
| <b>Total Monthly Household Income (Add lines 1-6)</b>           | \$     |                |

**PART E. SIGNATURE** - I certify (promise) that all information on this report is true and that all income is reported. I understand that the school will get federal/state funds based on the information I give. I understand that school officials may verify (check) the information.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Printed Name)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(Zip)

\_\_\_\_\_  
(Home Phone)

\_\_\_\_\_  
(Work Phone)

\_\_\_\_\_  
(Email Address)



**EASTERN UPPER PENINSULA  
INTERMEDIATE SCHOOL DISTRICT  
315 Armory Place, P.O. Box 883  
Sault Ste. Marie, MI 49783  
906 632-3373**

**REGISTRATION/CONSENT FOR  
SPECIAL EDUCATION TRANSFER STUDENT**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sp. Ed. Eligibility: \_\_\_\_\_  
Gender:  M  F SS#: \_\_\_\_\_ School: \_\_\_\_\_ Ethnic Group: \_\_\_\_\_  
Parent/Guardian (Please specify): \_\_\_\_\_ Home Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
Last School Attended: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone #: \_\_\_\_\_ FAX #: \_\_\_\_\_

I hereby authorize the release of any or all educational, medical, behavioral, and psychological information contained in the above name student's records to the Special Education Service Center. I authorize the use of telephone, telefax, photocopy, and e-mail for the transmission of this information. I understand that this authorization, except for the action already taken, may be voided by me at any time.

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

**Rule 340.1722e**

A handicapped person enrolled in a special education program in another school district, upon transfer to a new intermediate school district, and upon written consent of the parent, and with evidence of previous special education eligibility and placement, may be placed immediately in an appropriate special education program or service for a period not to exceed 30-school days, during which time an individualized planning committee shall be convened by the district of residence to review and possibly revise the person's individualized education program. This case shall have precedence over all other cases, except previous cases also being expedited under this rule.

I have read the above information, and I give the \_\_\_\_\_ school district my consent to:

- Immediately implement the student's current individualized education plan
- Immediately implement the student in the following program or service \_\_\_\_\_, and convene an individualized education team meeting within 30-days to develop a new individualized education program.

Date of enrollment: \_\_\_\_\_

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

**Reserved for School Use**

Received by: Local School District: \_\_\_\_\_ Date: \_\_\_\_\_

Area Service Coordinator: \_\_\_\_\_ Date(s): \_\_\_\_\_

Case Coordinator: \_\_\_\_\_ IEPC Due Date: \_\_\_\_\_

Other Team Members: \_\_\_\_\_ Records on File: ☆ Yes ☆ No

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

U.S. DEPARTMENT OF EDUCATION  
OFFICE OF INDIAN EDUCATION  
WASHINGTON, DC 20202  
TITLE VII STUDENT ELIGIBILITY CERTIFICATION  
Elementary and Secondary Education Act, Title VII, Part A, Subpart 1

**Parents:** Please return this completed form to your child's school. In order to apply for a formula grant under the Indian Education Program, your child's school must determine the number of Indian children enrolled. Any child who meets the following definition may be counted for this purpose. You are not required to complete or submit this form to the school. However, if you choose not to submit a form, the school cannot count your child for funding under the program. This form will become part of your child's school record and will not need to be completed every year. This form will be maintained at the school and information on the form will not be released without your written approval.

**Definition:** Indian means any individual who is (1) a member (as defined by the Indian tribe or band) of an Indian tribe or band, including those Indian tribe or bands terminated since 1940, and those recognized by the State in which the tribe or band reside; or (2) a descendant in the first or second degree (parent or grandparent) as described in (1); or (3) considered by the Secretary of the Interior to be an Indian for any purpose; or (4) an Eskimo or Aleut or other Alaska Native; or (5) a member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994.

NAME OF CHILD \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(As shown on school enrollment records)

School Name \_\_\_\_\_ Grade \_\_\_\_\_

NAME OF TRIBE, BAND OR GROUP \_\_\_\_\_

Tribe, Band or Group is: (check one)

Federally Recognized,  State  Organized Indian Group  
 Including Alaska Native  Recognized  Terminated  Meeting #5 of the  
Definition Above

Name of individual with tribal membership: \_\_\_\_\_

Individual named is (check one):  Child  Child's Parent  Child's Grandparent

Proof of membership, as defined by tribe, band, or group is:

A. Membership or enrollment number (if readily available) \_\_\_\_\_ OR  
Other (explain) \_\_\_\_\_

Name and address of organization maintaining membership data for the tribe, band or group:  
\_\_\_\_\_

I verify that the information provided above is accurate:

PARENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Mailing Address \_\_\_\_\_ Telephone \_\_\_\_\_

Notice: Public Reporting Burden Notice on Reverse Side