



2025-2026 Youth Enrollment Packet Checklist

Youth's Name _____

Grade

- Application for Admission
- Emergency/Medical Form
- Youth Residency Questionnaire
- State of Michigan District Report
- Education and Nutrition Benefits Form
- Last Report Card
- Birth Certificate
- Immunization Records
- Health Appraisal
- Concussion Form
- Technology Use Agreement
- Media Release
- Dress Code Policy and Expectations
- Parent-Academy Compact Form
- Youth Education and Culture Guide Agreement
- Parent/Guardian Photo Identification



YOUTH ENROLLMENT APPLICATION <i>(PLEASE PRINT)</i>				
YOUTH'S LEGAL INFORMATION				
First:		Middle:		Last:
Date of Birth:			Grade:	
Current Address:				Apt #
City:		State:	ZIP Code:	
Home Phone:		Mobile Phone:	Email:	
PARENT/GUARDIAN INFORMATION				
Guardian 1:			Guardian 2:	
Address:			Address:	
City:	State:	Zip Code:	City:	State:
Mobile Phone	Work Phone:		Mobile Phone	Work Phone:
Relationship to Youth:			Relationship to Youth:	
Email:			Email:	
EMERGENCY CONTACT				
Name:			Relationship to Youth:	
Address:			Phone:	
City:		State:	Zip Code:	
PRIOR SCHOOL ATTENDED				
Name of School:			Last Grade Completed:	
Address:				
City:		State:	Zip Code:	Phone:
DEMOGRAPHICS				
Is the youth of Hispanic/Latino descent? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Youth's Race: <input type="checkbox"/> Indigenous American Indian/Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> White/European/Middle Eastern				
<input type="checkbox"/> Asian/Far Eastern/Indian/Pakistani <input type="checkbox"/> Native Hawaiian/Pacific Islander				
Youth's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____			Youth's Preferred Pronoun (she/he): _____	
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Other:				
OTHER YOUTH IN THE HOME (UNDER 18 YRS. OLD)				
Please list the name and age of other school age or younger children living in the home.				
Name:		Birth Date:	Name:	
Name:		Birth Date:	Name:	
OTHER INFORMATION				
Does the youth have an existing IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No			Does the youth have an existing 504 Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
SIGNATURE				
I affirm that all information provided is true and accurate. I understand any false information provided by me may be subject to legal penalties for perjury. Further, I agree to notify the academy immediately of any custody, address or phone number change.				
Signature of Applicant:			Relationship to Youth:	Date:
THIS SECTION IS FOR ACADEMY USE ONLY				
<input type="checkbox"/> Application for Admission	<input type="checkbox"/> Last Report Card	<input type="checkbox"/> Technology Use Agreement	<input type="checkbox"/> Parent Photo Identification	<input type="checkbox"/> MSDS # _____
<input type="checkbox"/> Emergency/Medical Form	<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> Media Release	<input type="checkbox"/> Laptop # _____	<input type="checkbox"/> Campus _____
<input type="checkbox"/> Youth Residency Questionnaire	<input type="checkbox"/> Immunization Records	<input type="checkbox"/> Dress Code Policy	<input type="checkbox"/> Edgenuity # _____	<input type="checkbox"/> Entry Date _____
<input type="checkbox"/> SOM District Report	<input type="checkbox"/> Health Appraisal	<input type="checkbox"/> Compact Form	<input type="checkbox"/> Records Request: _____	<input type="checkbox"/> Exit Date _____
<input type="checkbox"/> Nutrition Benefits Form	<input type="checkbox"/> Concussion Form	<input type="checkbox"/> Youth Code of Conduct Agreement	<input type="checkbox"/> Records Received: _____	<input type="checkbox"/> Records Sent _____

Submit Completed Application to: ILL-Enrollment@InfinityInstitute.net – IIL Youth Enrollment – 13332 East Jefferson Avenue. Detroit, MI. 48215-2719



Emergency Contact and Medical Information for a Youth

School Year: 20__		Date of Birth:		Grade:	Gender:
Youth's Name:					<input type="checkbox"/> M / <input type="checkbox"/> F
					<input type="checkbox"/> Other
Parent's/Guardian's Name:		Parent's/Guardian's Name:			
Home Phone:	Work Phone:	Home Phone:	Work Phone:		
Address:		Address:			
City, State, Zip Code:		City, State, Zip Code:			
Email:		Email:			

Additional Emergency Contacts

Name	Phone Number	Relationship to Student

Medical Information

Hospital Preference: _____

Physician's Name:	Physician's Phone Number:
Insurance Company:	Policy Number:

Allergies/Special Health Considerations

Peanut Allergy? <input type="checkbox"/> Yes or <input type="checkbox"/> No	Any other food allergy? <input type="checkbox"/> Yes or <input type="checkbox"/> No If so, please list: _____
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Waiver of Liability

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

Parent's/Guardian's Signature	Date
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I give permission for my child to go on educational excursions and expeditions. I release Infinity Institute of Learning and individuals from liability in case of accident during activities related to Infinity Institute of Learning, as long as normal safety procedures have been taken.

Parent's/Guardian's Signature	Date
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Youth Residency Questionnaire

Date: _____

Youth's Name: _____ Grade: _____

Parent/Guardian's Name: _____

Address: _____

Phone: _____ E-mail Address: _____

The following questions are given to all youth to ensure Infinity Institute of Learning remains in compliance with federal law. Your answers will help Academy faculty and staff to determine if the youth is eligible for certain support services.

Do any of the Statements Apply to the Youth's Residency:

- Shelter Resident
- Shared Housing (Doubled Up)
- Transitional Housing
- Motel or Hotel Resident
- Campground/Tent
- Unsheltered
- Awaiting foster care or new foster care placement within 6 months
- Unaccompanied Youth (not in the physical custody of a parent or guardian and lacking a fixed, adequate, and regular nighttime residence)

Reviewed By: _____

Date Received: _____



Infinity Institute of Learning
Central Station Office of Support
13332 E. Jefferson Avenue
Detroit, MI 48215-2719
(O) 248.970.8343
(F) 248.923.5654

STATE OF MICHIGAN DISTRICT REPORT FORM

Name _____ Grade _____

Attention Parents:

In order to complete a report that is required by the State of Michigan, the following must be filled out. This form **must** be returned with all other required forms and necessary documents.

Please mark the box (x) in which district you reside (live in):

- Detroit Public Schools 82010
- Royal Oak 63040
- Oak Park 63250
- Berkley 63050
- Southfield 63060
- Ferndale 63020
- Bloomfield Hills 63080
- West Bloomfield Hills 63160
- Farmington 63200
- Redford Union 82110
- Other, please specify _____

Please mark the box (x) that applies to your child's ethnicity:

- American Indian or Alaska Native 100000
- Asian American 010000
- Black or African American 001000
- Native Hawaiian or other Pacific Islander 000100
- White 000010
- Hispanic or Latino 000001


State of Michigan Immunization Requirements

Children entering kindergarten thru 7th grade are required to be up to date on vaccines. Schools are required to report children's vaccine data to the local health department through the Michigan Care Improvement Registry (MICR). The School Immunization program monitors 70,000 children's immunization records in over 900 schools and child-care programs through MICR.



Vaccines Required for School Entry in Michigan

Whenever children are in group settings, there is a chance for disease to spread. Parents must follow state vaccine laws in order for their children to attend school. These laws are the minimum standard for preventing disease outbreaks in group settings. The best way to protect children from serious diseases is to follow the [Immunization Recommendations for Michigan](#). When following the recommended schedule children are fully protected and any school vaccination requirements are met.

	All kindergartners and 4–6-year-old transfer students	All 7th graders and 7–18-year-old transfer students
Diphtheria, Tetanus, Pertussis (DTP, DTaP, Tdap)¹	4 doses DTP or DTaP 1 dose must be at or after 4 years of age	4 doses diphtheria and tetanus or 3 doses if 1 st dose given on or after 1 year of age 1 dose Tdap at 11 years of age or older upon entry into 7 th grade or higher
Polio¹	4 doses or 3 doses if dose 3 was given on or after 4 years of age	
Measles, Mumps, Rubella (MMR)^{1, 2}	2 doses at or after 12 months of age	
Hepatitis B^{1, 2}	3 doses	
Meningococcal Conjugate (MenACWY)¹	None	1 dose at 11 years of age or older upon entry into 7 th grade or higher
Varicella (Chickenpox)^{1, 2}	2 doses at or after 12 months of age or current lab immunity or history of varicella disease	

¹Vaccines should be given at certain ages and at certain times (follow the [Immunization Recommendations for Michigan](#) for the recommended number of doses, correct spacing, and ages); this chart is based on Michigan school immunization requirements. We strongly encourage parents and providers to follow the AAP recommended schedule because school requirements are the minimum for protection. Follow this chart when assessing immunization status for school immunization requirements.²If the child has not received these vaccines, documented immunity/waiver is required. During disease outbreaks, incompletely vaccinated children may be excluded from school. Parents and guardians choosing to decline vaccines must obtain a certified non-medical waiver from a local health department. Read more about waivers at www.michigan.gov/immunize. 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.

MDHHS-Pub-1378 (Rev. 10-25)



Immunization Waivers

- Michigan parents or guardians opting out of the vaccinations required for children to attend childcare or school, must request a waiver from their local public health department. Waivers are required for children enrolled in kindergarten, 7th grade, new to a school district, or childcare whose parents opt not to vaccinate.
- If an unvaccinated child is exposed to a vaccine-preventable infection, or case(s) occur in the school or childcare, the child may be excluded from attending for the duration of the communicable period.
- The health department CANNOT issue Medical Waivers. A medical waiver is issued by a physician and submitted to the school or childcare when a child cannot receive vaccine for medical reasons. Waivers issued by the health department are for parents choosing not to vaccinate based on religious or philosophical beliefs or other concerns.

To obtain a non-medical immunization waiver for your child's school or childcare, please contact the Wayne County Department of Health, Human & Veterans Services at (734) 727-7125.

2025-2026 Education and Nutrition Benefits

Apply online:

Complete one application per household. Please use a pen (not a pencil).

STEP 1: List ALL children, infants, and students up to and including grade 12. Attach another sheet of paper if you need more space for names

List ALL children in the household. Do not forget to list infants, children attending other schools, children not in school, and children not applying for benefits. This includes children not related to you in your household.

Child's First Name	MI	Child's Last Name	Student?		School	Grade	Foster Child	Homeless Migrant, Runaway	If you checked any of these boxes, please refer to the Application Instruction's Step 1: Part C & Part D.
			Yes	No					
1) _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	
2) _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	
3) _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	
4) _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	
5) _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	

STEP 2: Do any Household Members (including you) currently participate in: SNAP, TANF, or FDPIR?

If **NO** > Go to STEP 3. If **YES** > Write a case number here, then go to STEP 4 (Do not complete STEP 3). Case Number: _____

(Write only one case number in this space)

STEP 3: List ALL household members and income for each member (before taxes and deductions). Skip this step if you answered "YES" to STEP 2.

A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income received by ALL children listed in STEP 1 here.

Child Income _____ How Often? Please put an X

Weekly Bi-Weekly 2x Month Monthly Annually

\$ _____

B. All Adult Household Members (including yourself)

List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes and deductions) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

PLEASE PRINT

Name of Adult Household Members (First and Last)	Earnings from Work	How often received?					Public Assistance/ Alimony/Child Support	How often received?					Pensions/Retirement/ All Other Income	How often received?				
		Weekly	Bi-Weekly	2x Month	Monthly	Annually		Weekly	Bi-Weekly	2x Month	Monthly	Annually		Weekly	Bi-Weekly	2x Month	Monthly	Annually
1) _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Household Members (Children and Adults) _____ Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member (if Applicable) _____ Check if no SSN

STEP 4: Contact information and adult signature. RETURN COMPLETED FORM TO:

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal Funds, and that school officials may verify (confirm) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws".

Street Address (if available) _____ Apt# _____ City _____ State _____ Zip _____ Phone (Optional) _____ Email (Optional) _____

Printed Name of Adult Signing Form _____ Signature of Adult _____ Today's Date _____

SOURCES AND EXAMPLES OF INCOME: for additional information in income, please refer to the instructions that accompany this application.

Sources of Child Income	Examples
Earnings from work	A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivor's Benefits	A child is blind or disabled and receives Social Security Benefits. A parent is disabled, retired, or deceased, and their child receives Social Security benefits.
Income from person outside the household	A friend or extended family member regularly gives a child spending money.
Income from any other source	A child receives regular income from a private pension fund, annuity, or trust.

Sources of Adult Income	Examples
Earnings from work	Salary, wages, cash bonuses / Net income from self-employment (farm or business) -If you are in the U.S. Military: -Basic pay and cash bonuses (do NOT include combat pay, FSSA or privatized housing allowances) -Allowances for off-base housing, food and clothing
Public Assistance / Alimony / Child Support	-Unemployment Benefits -Workers compensation -Supplemental Security Income (SSI) -Cash assistance from State or local government -Alimony payments-Child support payments -Veteran's benefits -Strike benefits
Pensions / Retirement / All Other Income	-Social Security (including railroad retirement and black lung benefits) -Private pensions or disability benefits -Annuities -Regular income from trusts or estates -Investment income -Earned interest -Regular cash payments from outside household

OPTIONAL: Children's ethnic and racial identities. This information is kept confidential and may be protected by the Privacy Act of 1974.

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced-price meals.

Ethnicity (check one): Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish Culture or origin, regardless of race) Not Hispanic or Latino

Race (check one or more): American Indian or Alaskan Native Asian Black or African American Native Hawaiian or Other Pacific Islander White

Use of Information Statement: The Richard B. Russell National School Lunch Act requires that we use information from this application to see who qualifies for free or reduced price meals. We can only approve complete forms. We may share your eligibility information with education, health, and nutrition programs to help them deliver program benefits to your household. Inspectors and law enforcement may also use your information to make sure that program rules are met. Please be sure to provide the last four numbers of the Social Security number of the adult household member who signs the application. If the adult does not have one, 'Check if no Social Security Number' Applications for a foster child do not need to list a Social Security number. Applications for children in households receiving Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR) do not need to list a Social Security number. Some children qualify for free meals without an application. Please contact your school to get free meals for a foster child, and children who are homeless, migrant, or runaway.

The contact information below is solely to file a complaint of discrimination: In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at [USDA Program Discrimination Complaint Form](https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf) (https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf), from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA

(1) by: mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (833) 256-1665 or (202) 690-7442; or
(3) email: program.intake@usda.gov.

***Do not mail applications to this address, only complaints of discrimination**

This institution is an equal opportunity provider.

DO NOT FILL OUT: For School Use Only

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12. Do not annualize income to determine eligibility unless more than one income frequency is listed.

Total Income: \$ _____ \$ _____ \$ _____ \$ _____ \$ _____ **Household Size:** _____ **Categorical Eligibility:** _____ **Eligibility:** _____
Weekly Bi-Weekly 2x Month Monthly Annual Free Reduced Denied

 Determining Official's Signature Date Confirming Official's Signature Date Verifying Official's Signature Date

HEALTH APPRAISAL

Michigan Department of Health and Human Services

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, dentist, dental therapist, and dental hygienist.

(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)	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 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)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2	Anaphylaxis	
<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, please 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"/>		Other (please describe) _____	

Reason for Medication		
Concussion History		
Parent/Guardian Signature	Date	Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials _____

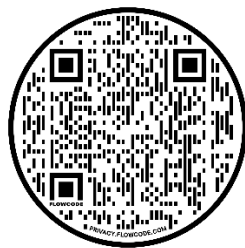
SECTION II – PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Test and Measurements						
Yes	No	Was child tested for	Tests and results	Normal	Referred	Under care
<input type="checkbox"/>	<input type="checkbox"/>	Vision Date _____	Visual Acuity			
			Muscle Imbalance			
			Other			
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Date _____	<input type="checkbox"/> Audiometer (R= Right, L=Left)	R/L	R/L	
			<input type="checkbox"/> OAE (R= Right, L=Left)	R/L	R/L	
			<input type="checkbox"/> Other (R= Right, L=Left)	R/L	R/L	
<input type="checkbox"/>	<input type="checkbox"/>	Urinalysis	Sugar			
			Albumin			
			Microscopic			
<input type="checkbox"/>	<input type="checkbox"/>	Blood Lead Level Date _____	Level _____ ug/dl			
<input type="checkbox"/>	<input type="checkbox"/>	Height & Weight	Height			
			Weight			
		Other _____	Other _____			
<input type="checkbox"/>	<input type="checkbox"/>	Hemoglobin/Hematocrit	➡			
<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure	Reading _____			

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.

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 III – IMMUNIZATIONS

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

Vaccines (Circle Type)	Date Administered mm/dd/yy		Vaccines (Circle Type)	Date Administered mm/dd/yy		
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	3	
	2	4		2		
DTaP/DTP/DT/Td	1	4	Influenza (IIV/LAIV)	1	3	
	2	5		2	4	
	3	6	Meningococcal MenACWY (MCV4)	1	3	
Tdap	1		Meningococcal B (Bexsero, Trumenba)	1	3	
				2		
<i>Haemophilus Influenzae</i> type b (HIB)	1	3	Human Papillomavirus (9vHPV, 4vHPV, 2vHPV)	1	3	
	2	4		2		
Polio (IPV/OPV)	1	4	Additional Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)	
	2	5		1		
	3			2		
Pneumococcal Conjugate (PCV7/PCV13)	1	3	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable.	3		
	2	4				
Rotavirus (RV1/RV5)	1	3	* 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.			
	2					
Measles, Mumps, Rubella (MMR/MMRV)	1	3				
	2					
Varicella (Chickenpox), (Var, MMRV)	1	2				
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date _____				Parent/Guardian refused recommended immunizations at visit: <input type="checkbox"/>		
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)

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	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: _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> Other _____ _____
Other Recommendations		

SECTION V – DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS (OPTIONAL)

Child's Name	Has received	<input type="checkbox"/> Dental Exam	<input type="checkbox"/> Dental Assessment
Findings and Recommendation (Check all that apply)			
<input type="checkbox"/> No Urgent Needs	<input type="checkbox"/> Routine Care Needed	<input type="checkbox"/> Treated Decay	
<input type="checkbox"/> Restorative/Urgent Needs for Dental Care	<input type="checkbox"/> Untreated Decay	<input type="checkbox"/> Further Referral for Specialist	
Signature			Date
Check One			
<input type="checkbox"/> Dentist	<input type="checkbox"/> Dental Therapist	<input type="checkbox"/> Dental Hygienist	

PHYSICIAN'S SIGNATURE

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

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 will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

PARENT & ATHLETE CONCUSSION INFORMATION SHEET



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 bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports one or more symptoms of concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury. The athlete should only return to play with permission from a health care professional experienced in evaluating for concussion.

DID YOU KNOW?

- Most concussions occur without loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

SYMPTOMS REPORTED BY ATHLETE:

- Headache or “pressure” in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not “feeling right” or is “feeling down”

SIGNS OBSERVED BY COACHING STAFF:

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

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. An athlete 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 or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously)

WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

1. If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.
2. Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, and playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.
3. Remember: Concussions affect people differently. While most athletes 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.

WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. They can even be fatal.

STUDENT-ATHLETE NAME PRINTED

STUDENT-ATHLETE NAME SIGNED

DATE

PARENT OR GUARDIAN NAME PRINTED

PARENT OR GUARDIAN NAME SIGNED

DATE

JOIN THE CONVERSATION  www.facebook.com/CDCHeadsUp



HEADS UP

TO LEARN MORE GO TO >> [WWW.CDC.GOV/CONCUSSION](https://www.cdc.gov/concussion)

Content Source: CDC's Heads Up Program. Created through a grant to the CDC Foundation from the National Operating Committee on Standards for Athletic Equipment (NOCSAE).



Technology Resources and Use of Personal Technology Devices Agreement

Technology supports teaching and learning. All youth are held responsible for their actions and activities while using Academy/District approved technology resources and personal devices at the Academy, and at pre-approved co-curricular/extracurricular events or activities.

1. All youth are responsible for compliance with District guidelines and Board policies, local, state, and federal laws while using technology resources and personal/Academy technology devices.
2. All youth are responsible for using technology resources and personal/Academy technology devices in an ethical manner for educational purposes, including adhering to copyright guidelines; devices may not be used to cheat on assignments or tests.
3. All users are responsible for properly using and caring for the Academy technology including computers, computer peripherals, software, technology devices and access to data networks.
4. Staff has the discretion to allow and regulate the use of technology including personal devices in accordance with District guidelines and policies.
5. All youth are prohibited from using another individual's user name or password for any reason.
6. All youth may use only licensed and/or pre-approved software that has been installed on the computers by the Academy district technology department. All users may not download/install software to Academy/District-owned devices without prior approval.
7. Personal devices and portable software may only be used to access content which is relevant to classroom curriculum.
8. All youth are responsible for the content of work created and/or saved in voice, video or data files.
9. All youth may be held financially responsible for intentional waste or damage to school supplies and equipment.
10. All youth who do not use the technology resources and personal/Academy technology devices appropriately could lose the privilege, and result in disciplinary action.
11. Youth may not use devices to record, transmit or post images or video of a person or persons on campus during Academy activities and/or after school hours, unless otherwise allowed by a teacher or administrator with prior approval of the youth's parent or guardian.
12. Devices are not to be used under any circumstances in the following areas/situations:
 - a. Restrooms
 - b. Any private areas used for the purposes of clothing changing
 - c. Any other areas as designated by administration
 - d. During emergency drills or situations
13. Access to all media platforms, including social media sites, video streaming services, and online forums, is strictly prohibited on campus unless specifically authorized for educational purposes by a teacher or administrator. Any unauthorized use of such media platforms will result in disciplinary action and possible loss of technology privileges.
14. Youth are permitted to use artificial intelligence (AI) tools to assist with Academy work only when explicitly allowed by teachers or administrators. Use of AI must comply with all academic integrity guidelines, and any work submitted must represent the youth's own understanding and effort.



15. Youth must properly cite any AI-generated content or assistance according to school standards. Unauthorized or inappropriate use of AI, including plagiarism or misrepresentation, may result in loss of technology privileges and disciplinary action.
16. All AI usage should respect privacy, ethical considerations, and data security. Youth are responsible for ensuring their use of AI tools does not violate Academy policies or applicable laws.
17. Youth acknowledges that by using personal/academy technology devices they understand that teachers or other supervising personnel may review files and communications to ensure that all users are demonstrating responsible use.
18. Personal calls and text messages on youth mobile devices are strictly prohibited during Academy hours, including all instructional and supervised activities. Devices may not be used for personal communication except in cases of emergency and only with prior approval from a teacher or administrator.
19. The District is not responsible for the loss, theft, damage or vandalism to youth cell phones, electronic devices or any other youth property. Youth are strongly encouraged not to leave their property unattended or unsecured.
20. Technological devices will be confiscated if utilized inappropriately.

By signing below, both the youth and parent/guardian acknowledge that they have read the IIL Youth Technology Use and Agreement and agree to adhere to all policies outlined in this document. They understand the importance of responsible technology use and accept the consequences for any violations of the agreement.

Youth's Name (Printed) _____ Grade _____

Youth's Signature _____ Date _____

Guardian's Name (Printed) _____

Guardian's Signature _____ Date _____



YOUTH MEDIA RELEASE



To the parent or guardian of: _____
(Print Youth's Name)

On occasion, Infinity Institute of Learning - approved non-commercial video, photographic and/ or audio production crews may be present at the school or at an Infinity Institute of Learning - sanctioned activity your child attends, in order to highlight the activity, school, student, original student work or the District in the interest of promoting public education. If you consent to your child's participation or showcase of their original work in the video/photographic/ audio, productions/interviews/activities or social media postings that may take place, please sign below after reading the following.

I, _____, am the parent/guardian of the above-named youth.
(Print Parent/Guardian Name)

In the interest of public education, I hereby authorize the Infinity Institute of Learning, its Board of Directors, and the non-commercial production crews, acting through their authorized employees or agents, to use, publish, and copyright audio and/or visual reproductions of the above-named youth's voice and/or image, and/or original youth work alone or with other persons, with or without the use of the youth's name for the sole use in the interest of public education connected with a IIL authorized project.

This release is in effect in perpetuity from the date _____
(Print Youth's Name)

becomes a youth of _____ until the date their
(Print Academy Name)

status at IIL or at the Academy as a youth terminates. I hereby release and hold the Infinity Institute of Learning harmless from any liability, any and all injuries, claims, damages or costs arising from the use of images or recordings of any type and waive any request for remuneration.

Parent/Guardian Signature Date

Address, City, Zip



Dress Code Policy and Expectations

Dress Code Aspect	Details
Intention	Promote inclusive and positive school community
Applicability	Regular school days, summer school days, after-school events, school-related events, course/club activities, graduation ceremonies, dances, prom, athletic events
Enforcement	Consistent, equitable, no marginalization or oppression based on race, sex, gender identity, gender expression, sexual orientation, ethnicity, religion, cultural observance, household income, body type/size
Non-Discrimination	ILL does not discriminate on race (including hair texture/protective hairstyles), color, national origin, sex, sexual orientation, gender identity, disability, religion, height, weight, citizenship, marital/family status, ancestry, genetic information, or any legally protected category
Reporting Discrimination	Report concerns to Academy staff and/or Civil Rights and Compliance Department (CRC)
Uniform Requirement	Solid collar shirt, polo, or ILL t-shirt and skirt, pants, or shorts
Uniform Details	Purple, Green or Golden Rod Polo or Oxford Shirt, Khakis or Black Bottoms, Blazor
Uniform Exclusion	Youth can be excluded from the Academy for not wearing uniforms
Uniform Concerns	Address with Academy Principal
Financial Need for Uniform	Inquire about the ILL Uniform Closet or low-cost purchasing options
General Dress Code Requirements	Certain clothing may be required for safety in classes/activities (physical education, trade classes, chemistry, band, choir, dance, drama, theater)
Neatness	Youth are responsible for keeping themselves and clothes neat and clean
Hair Style	Youth may wear their hair in any style
Head Coverings	Not allowed in school building unless for religious, cultural, medical, or disability-related reasons (e.g., hijab, yarmulke, Gele, protective helmets)
PPE	Students may wear medical face masks, gloves to guard against health-related risks
Prohibited Clothing	Styles that endanger students, bedtime attire (pajamas, undershirts, undergarments as outerwear)



Infinity Institute of Learning
Central Station Office of Support
13332 E. Jefferson Avenue
Detroit, MI 48215-2719
(O) 248.970.8343
(F) 248.923.5654

Prohibited Displays	Clothing/tattoos may not display statements/pictures related to drugs, alcohol, tobacco, sex, hate, violence, gang affiliations
Prohibited Attire	Weapons (chain belts, wallet chains), obscene/disruptive jewelry, hair rollers/curlers, flip-flops, house slippers, steel-toe-shoes/boots, footwear that is a safety hazard, ski-mask or similar face mask

By signing below, I acknowledge that I have read, understood, and accept the Infinity Institute of Learning dress code policy outlined above. I agree to adhere to these guidelines and understand the importance of maintaining a safe and respectful environment for all youth.

Youth's Name: _____

Signature _____

Date _____

By signing below, I acknowledge that I have read, understood, and accept the Infinity Institute of Learning dress code policy outlined above as the parent or guardian. I agree to support and enforce these guidelines and understand the importance of maintaining a safe and respectful environment for all youth.

Parent/Guardian Name: _____

Signature _____

Date _____



Parent-Academy Compact
“A Compact for Success!”

Infinity Institute of Learning, in partnership with parents and the community, will prepare youth to become critical thinkers and life long learners. We will strive to produce responsible citizens who achieve their maximum potential in an ever changing society.

PARENT/GUARDIAN AGREEMENT

(Any person who is interested in helping this student may sign in lieu of the parent.)

I want my child to achieve. Therefore, I will encourage them by doing the following:

- See that my child is punctual and attends school regularly.
- Support the school in its efforts to maintain proper discipline.
- Establish a time for homework and review it regularly.
- Volunteer according to the expected hours
- Encourage my child’s efforts and be available for questions.
- Stay aware of what my child is learning.
- Read with my child and let my child see me read daily.

Signature _____

Date _____

YOUTH AGREEMENT

It is important that I work to the best of my ability. Therefore, I shall strive to do the following:

- Wear my school uniform properly daily. Dress for SUCCESS!
- Attend school regularly.
- Come to school each day READY to learn.
- Complete and return homework assignments.
- Study every night.
- Follow the Student Success Guide.
- Try my BEST all the time.

Signature _____

Date _____

TEACHER AGREEMENT

It is important that students achieve. Therefore, I shall strive to do the following:

- Provide homework assignments for students.
- Provide necessary assistance to parents so that they can help with the assignments.
- Encourage students and parents by providing information about student progress.
- Use special activities in the classroom to make learning enjoyable.
- Teach based on the State of Michigan Core and/or National Standards requirements.

Signature _____

Date _____

PRINCIPAL AGREEMENT

I support this form of parent involvement. Therefore, I shall strive to do the following:

- Provide a safe and secure environment that allows for positive communication between the teacher, parent, and student.
- Encourage teachers to regularly provide Exemplary Instruction and issue Quality Work Assignments.

Signature _____

Date _____