



# COLE ACADEMY

1915 W. Mt. Hope Ave.  
Lansing, MI 48910  
Phone 517.372.0038  
Fax 517.372.1446  
[www.coleacademy.org](http://www.coleacademy.org)

Dear Future Husky,

We are so pleased you have chosen our school for your child's future! Enclosed in this packet you will find many important documents. Your application to Cole Academy is **NOT** considered complete and does not secure you a seat until **ALL** the following items are received. Please complete each form carefully and return to the school by Thursday, March 13, 2025. Incomplete applications will not be considered. If there are more applications than seats available, a lottery will take place on Thursday, March 20, 2025 @ 4 pm at the Cole Academy East campus.

| Kindergarten Checklist  | 1 <sup>st</sup> Grade – 5 <sup>th</sup> Grade Checklist   |
|---|---|
| <ul style="list-style-type: none"><li><input type="checkbox"/> Enrollment Application</li><li><input type="checkbox"/> Home Language Survey</li><li><input type="checkbox"/> Kindergarten Development History</li><li><input type="checkbox"/> Kindergarten Behavior History</li><li><input type="checkbox"/> Proof of Residency (copy of driver's license or current utility bill)</li><li><input type="checkbox"/> Copy of original birth certificate</li><li><input type="checkbox"/> Copy of immunizations records from the Health Department</li><li><input type="checkbox"/> Oral Health Screening</li><li><input type="checkbox"/> Vision Screening or future date in which your child is scheduled to get vision tested.</li><li><input type="checkbox"/> Consent for Disclosure of Immunization Information (FERPA)</li><li><input type="checkbox"/> Current IEP Documentation (If applicable)</li></ul> | <ul style="list-style-type: none"><li><input type="checkbox"/> Enrollment Application</li><li><input type="checkbox"/> Home Language Survey</li><li><input type="checkbox"/> CA60 Records Request</li><li><input type="checkbox"/> Verification of Educational Records:<ul style="list-style-type: none"><li>o <u>MUST</u> be signed by current school administrator</li><li>o <u>MUST</u> include a copy of most recent report card</li><li>o <u>MUST</u> include attendance records</li></ul></li><li><input type="checkbox"/> Proof of Residency (copy of driver's license or current utility bill)</li><li><input type="checkbox"/> Copy of original birth certificate</li><li><input type="checkbox"/> Copy of immunizations records from the Health Department</li><li><input type="checkbox"/> Consent for Disclosure of Immunization Information (FERPA)</li><li><input type="checkbox"/> Current IEP Documentation (If applicable)</li></ul> |

Thank you for partnering with Cole Academy for your child's education. You can reach the office staff at (517) 372.0038 if you have any questions or concerns. Thank you again and welcome to our Cole Academy family!





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**FOR OFFICE USE ONLY-- Missing Forms:**  
All: ☐BC ☐Imm ☐Res. ☐HL ☐IEP/SPED  
☐Cust/Guard  
K-Only: ☐Vision ☐KBH ☐Oral  
1<sup>st</sup>-5<sup>th</sup> Only: ☐VER ☐Rec

## 2025/2026 ENROLLMENT APPLICATION

### STUDENT INFORMATION

Child Name \_\_\_\_\_  
Last First M.I.  
Birth Date \_\_\_\_\_ ☐Male ☐Female

### Student's Mailing Address:

Street/# \_\_\_\_\_  
City, Zip \_\_\_\_\_  
County: ☐Ingham ☐Eaton ☐Other \_\_\_\_\_  
What school **DISTRICT** do you currently **live in**? \_\_\_\_\_

Student's Primary Phone# \_\_\_\_\_ ☐Mom ☐Dad ☐Other

Grade Student **Applying For/Entering:** ☐K ☐1<sup>st</sup> ☐2<sup>nd</sup> ☐3<sup>rd</sup> ☐4<sup>th</sup> ☐5<sup>th</sup>

- Has your child ever been retained? ☐Yes ☐No
- Has your child's school ever recommended retention and you refused? ☐Yes ☐No
- Has your child ever been suspended or expelled from school? ☐No ☐Yes—(If yes-Please explain on separate piece of paper.)

*\*Cole Academy schools reserve the right to decline admission to students who have been suspended or in the process of being suspended from another school district.*

- Does your child have an Individual Education Plan (I.E.P.), Special Ed ☐Yes -Please list Primary Disability\_\_\_\_\_

- Has your student ever had any of the following services? ☐Speech ☐ABA Therapy ☐O.T. ☐P.T. ☐Therapy ☐CMH ☐ECSE

☐ If none of the above services apply, please check this box.

Child's ethnic/race group: *check all that apply*

- ☐Hispanic or Latino Heritage ☐Black or African American ☐Asian American  
☐American Indian or Alaska Native ☐White

Names & grades of other siblings attending Cole Academy:

Name Grade

Name Grade

With whom does your child reside? \_\_\_\_\_  
(i.e. parent(s), grandparent, aunt, etc.)

Is your child currently homeless? (i.e. family living w/ another family, hotel, temporary housing) ☐Yes ☐No

Is this child a Foster Child? ☐Yes ☐No

Are there custody or guardianship restrictions that we need to be aware of and have copies for our files? ☐Yes ☐No

## CONTACT INFORMATION

**Mother's Name** \_\_\_\_\_

Last

First

Address (If different than student's mailing address) \_\_\_\_\_

*Street number & name*

*City/State/Zip*

Phone #1 \_\_\_\_\_ ☐ cell ☐ work

Phone #2 \_\_\_\_\_ ☐ cell ☐ work

Email \_\_\_\_\_

**Father's Name** \_\_\_\_\_

Last

First

Address (If different than student's mailing address) \_\_\_\_\_

*Street number & name*

*City/State/Zip*

Phone #1 \_\_\_\_\_ ☐ cell ☐ work

Phone #2 \_\_\_\_\_ ☐ cell ☐ work

Email \_\_\_\_\_

List any party restrictions (i.e. Christmas, Halloween, etc.) \_\_\_\_\_

Will your child be walking to or from school? ☐ Yes ☐ No

How did you hear about Cole Academy? \_\_\_\_\_

\*If all seats are full at the Lansing campus, I would consider enrollment at the East campus: ☐ Yes ☐ No

By signing this form, I am accepting enrollment for my child.

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

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

*\*Failure to respond or untruthful responses may result in refusal of this application.*

*The Academy prohibits all forms of discrimination in its educational programs and activities.*



## COLE ACADEMY

### STATE BOARD OF EDUCATION APPROVED HOME LANGUAGE SURVEY\*

**Cole Academy** is collecting information regarding the language background of each of its students. The information will be used by the district to determine the number of children who should be provided bilingual instruction according to Sections 380.1152-380.1157 of the School Code of 1995, Michigan's Bilingual Education Law. Would you please help by providing the following information?

Thank you very much for your cooperation.

Student Name \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_

Michigan welcomes families of all language backgrounds. Speaking more than one language is a valuable asset! Please answer the two questions below. If your response to either question is a language other than English, the school district will give an assessment to see if your student may benefit from English language support.

What language is used most at home? \_\_\_\_\_

What language is used most by the student? \_\_\_\_\_

Was the student born outside of the US or Puerto Rico? ☐ Yes ☐ No

If yes, when did the student enter the US schools? \_\_\_\_\_

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

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date

*Translation of this survey form in Spanish, Arabic, French, Italian & Ojibwa is available at the Office of Field services at 517.373.6066.*





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## KINDERGARTEN DEVELOPMENTAL HISTORY

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First M.I.

Does your child have a current Individual Education Plan (I.E.P.) or other special accommodations?

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Has your student ever had any of the following services? ☐Speech ☐ABA Therapy ☐O.T. ☐P.T.

☐Therapy ☐CMH ☐ECSE

☐ If none of the above services apply, please check this box.

### Siblings within the Child's Home

Names & Age/Grade

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Are there any issues at home that would help us understand your child better? \_\_\_\_\_

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Any concerns with how your child will eat at school? \_\_\_\_\_

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**Please go to side 2**

How would you describe your child as a student? \_\_\_\_\_

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What would you say are some of your child's strengths? \_\_\_\_\_

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What would you say will cause your child the most difficulty? \_\_\_\_\_

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Anything else you would like us to know? \_\_\_\_\_

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## KINDERGARTEN BEHAVIOR HISTORY

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Please provide the names of school and district, as well as the address:

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

Please check all boxes that apply. Has your student ever attended any of the following:

☐ Great Start Readiness Program (GSRP) ☐ Head Start ☐ Preschool ☐ Daycare ☐ Taken Kinder (Repeat) ☐ ECSE ☐ Other \_\_\_\_\_

Has your student ever had any of the following services? ☐ Speech ☐ ABA Therapy ☐ OT ☐ PT ☐ Therapy ☐ CMH

If your scholar has NEVER had any of the above services, please check this box ☐

### **\*\*THIS SECTION IS TO BE COMPLETED BY CHILD'S CURRENT OR PREVIOUS SCHOOL/PRESCHOOL/DAY CARE/GSRP**

Dear School Administrator, please provide the following information regarding the student mentioned above who attends your school.

Has this student had a history of violent behavior towards themselves, teachers or other students? ☐ Yes ☐ No

If yes, please explain or attach documentation: \_\_\_\_\_

Has this student ever been suspended? ☐ Yes ☐ No Has this student ever been expelled? ☐ Yes ☐ No

Does this student have a 504? ☐ Yes ☐ No Does this student have an IEP? ☐ Yes ☐ No

Has this student been absent 10% or more of the enrolled days? ☐ Yes ☐ No

If yes, please explain or attach documentation: \_\_\_\_\_

\_\_\_\_\_  
Signature of School Administrator

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Administrator

\_\_\_\_\_  
School Name/District





*Cole Academy*

**FERPA 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 students name, Date of Birth, gender, and address with local and state health departments will help to keep your child safe from vaccine preventable diseases. The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g, requires written parental consent before personally identifiable information from your child's education records is disclosed to the health department. If your child is 18 or over, he or she is an "eligible student" and must provide consent for disclosures of information from his or her education records.

You may withdraw your consent to share this information in writing at any time.

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*I authorize \_\_\_\_\_ Cole Academy \_\_\_\_\_ to release my child's immunization record to the Michigan Department of Health and Human Services and Local Health Department. I understand this information will be used to improve the quality and timeliness of immunization services and to help schools comply with Michigan Law. This includes any immunization information and limited personally identifiable information from the school.*

Student's Name: \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_

Grade \_\_\_\_\_

Signature of Parent/Guardian  
or Eligible Student: \_\_\_\_\_ Date: \_\_/\_\_/\_\_

Printed Parent/Guardian Name: \_\_\_\_\_



# MDHHS-6067, KINDERGARTEN ORAL HEALTH ASSESSMENT

Michigan Department of Health and Human Services (MDHHS)

(New 8-23)

## SECTION 1 – STUDENT INFORMATION

Child's Name (Last, First, Middle)

Date of Birth

Address (Number, Street, City, Zip Code)

Home/Cell Phone Number

Parent/Guardian Name (Last, First, Middle)

Parent/Guardian Email

School Name

## SECTION 2 – DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS

(Licensed dental professional must complete this section)

Date of Service

Type of Service

☐ Dental Exam

☐ Dental Assessment

Findings (Check all that apply)

☐ No findings

☐ Treated decay

☐ Untreated decay

Recommendations (Check **one**)

☐ Routine care

☐ Referral for dental treatment

☐ Referral for urgent dental care

Provider Type (Check **one**)

☐ Dentist

☐ Dental Therapist

☐ Dental Hygienist

Provider Signature

Agency/Local Health Department

Provider Name (Print)

Phone Number

Additional Comments

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.