KALAMAZOO ACADEMY FOR BEHAVIORAL & ACADEMIC SUCCESS

New Student School Enrollment Checklist

Student Name: _____

- ☐ Enrollment Application
- ☐ ABA Intake Packet **(if ABA services are required)**
- ☐ Enrollment Agreement
- ☐ Signed Emergency Medical Release Form
- ☐ Signed Medication Administration Form
- ☐ Signed Media Release Form
- ☐ Copy of Birth Certificate
- ☐ Copy of Social Security card (parent/guardian & student)
- ☐ Copy of Driver's License (parent/guardian)
- ☐ Copy of Insurance Card(s) (Front and Back) **(if ABA services are required)**
- ☐ Proof of immunizations
- ☐ Proof of physical examination within the last year on health (health appraisal form)
- ☐ Proof of guardianship, if you are not the child's parents (Court Custody Documentation, Department of Children and Families Placement Letter, or Educational Guardianship)
- ☐ Student's CA-60 record (i.e., IEPs) from previous school

All listed documents must be submitted along with a completed packet.

School Registration 2026/2027. Please fill out the form completely.

Student's Full Name: _____

Address _____ City: _____ State: _____ Zip: _____

Date of Birth (MM/DD/YYYY): ____/____/_____ Grade: _____ Sex: _____Social Security Number: _____

Race: (required by DOE, please check one)

Hispanic/Latin		Black or African American	
American Indian or Alaska Native		Native Hawaiian or Pacific Islander	
Asian		White/Caucasian	

Parent/Guardian Information:

Parent/Guardian Name: _____ Relation to Student: _____

Home Address:_____

Personal Phone: _____ Work Phone: _____

Email: _____

Parent/Guardian Name: _____ Relation to Student: _____

Home Address:_____

Personal Phone: _____ Work Phone: _____

Email: _____

Emergency Contact Information:

Emergency Contact #1: _____ Relation to Student: _____

Home Address:_____

Personal Phone: _____ Work Phone: _____

Email: _____

Emergency Contact #2: _____ Relation to Student: _____

Home Address:_____

Personal Phone: _____ Work Phone: _____

Email: _____

With whom does the student live? (Name) _____

In the event that the parents are not together, divorced, or become divorced, please provide and attach a copy of the legal documents regarding your child's educational decision making.

Please list the name(s) of individuals authorized to pick up your child:

Name: _____ Relationship: _____ Phone: _____

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KABAS School Schedule

The first day of school is **Tuesday, September 8th.** If there are any changes or delays, the KABAS Director will connect with you directly. The school will operate Monday-Friday 8AM-4PM. Classes will start at 9AM until 3:30PM. The schedule will be as follows:

- Drop off window: 8:30-9AM
- Pick up window: 3:30-4PM

The school will be in session all year, observing all federal holidays. The KABAS calendar will be located on our website (kalamazooschool.org) and will provide information about scheduled holidays, half days, and closures. For the school supply list, please see documents in the enrollment packet.

Clinic Registration 2026/2027. Please fill out the form completely.

Student's Full Name: _____

Address: _____City: _____ State: _____ Zip:_____

Date of Birth (MM/DD/YYYY): _____/_____/_____ Grade: _____ Sex: _____

Social Security Number: _____

Race: (required by DOE, please check one)

Hispanic/Latin		Black or African American	
American Indian or Alaska Native		Native Hawaiian or Pacific Islander	
Asian		White/Caucasian	

Parent/Guardian Information:

Parent/Guardian Name: _____ Relation to Student: _____

Home Address:_____

Personal Phone: _____ Work Phone: _____

Email: _____

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Home Address:_____

Personal Phone: _____Work Phone: _____

Email: _____

Emergency Contact #2: _____Relation to Student: _____

Home Address:_____

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With whom does the student live? (Name) _____

*In the event that the parents are not together, divorced, or become divorced, please provide and attach a copy of the legal documents regarding your child's educational decision making.

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Name:_____Relationship:_____Phone: _____

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Name:_____Relationship:_____Phone: _____

Previous Evaluations/Assessments

Has the client ever been assessed/evaluated by an Occupational Therapist, Speech and Language Therapist, Psychiatrist, Psychologist, Special Educator, or other mental health counselor?
Yes____ No____Unknown____

If **yes**, please provide the following information:

Name: _____Type of Specialist:_____ Date of evaluation: _____
Purpose of Evaluation / Services:_____
Results of Evaluation:_____

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Educational History

Please list any schools that the client has attended:

School Name: _____ School District: _____
Years of attendance: _____ Grade Levels: _____

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Years of attendance: _____ Grade Levels: _____

Is the client receiving, or have they received special services or accommodations at school? If **yes**, please explain what type: (e.g. IEP, 504 Plan):

_____

_____

Client's Interests

Please indicate anything that the clinicians should know when working with him/her.

1. Preferences (favorite activities, food, interests/topics, sensory):
   _____
   _____
   _____
2. Dislikes (aversions):
   _____
   _____
   _____
3. Other:
   _____
   _____
   _____

Concerns

1. Reason for seeking ABA Services [Please explain]:

_____
_____
_____

2. Please list client strengths:

_____
_____
_____3. Areas of

Concerns [Please indicate by marking the box and briefly explaining each domain]

Cognitive/Learning	**Motor**	**Behavior**
Social	**Language**	**Peer Interaction**
Play/Leisure	**Self Help (dressing, toileting, etc.)**	**Academics**
Executive Functioning	**Dietary/Allergies**	**Other**

Cultural Considerations

Please describe any important cultural practices, rituals, traditions, or beliefs that you believe are important for us to be aware of prior to initiating a therapeutic relationship.

_____

_____

_____

Coordination of Care

Please list and provide contact info for all other providers for your child:

Primary care provider: _____ Contact: _____

School teacher: _____Contact: _____

Speech Language Pathologist: _____ Contact: _____

Occupational Therapist : _____ Contact: _____

Other : _____ Contact: _____

Other : _____ Contact: _____

Other : _____ Contact: _____

INSURANCE BILLING INFORMATION and AUTHORIZATION

I authorize my insurance provider(s) listed below to make payments directly to the Kalamazoo Academic for Behavioral and Academic Success (KABAS) for services rendered.

I understand that a copy of my insurance card (front and back) will be retained in my client/patient file for billing purposes.

I agree that private information may be shared with my insurance carrier for billing purposes

Name of Primary Sponsor: _____SS# _____

Name of Insurance Carrier _____Policy # _____

Name of Secondary Sponsor: _____SS# _____

Name of Insurance Carrier: _____Policy # _____

Medicaid Identification #_____

Tuition and Fees

Full-Time Tuition

For the 2026/2027 academic year, the tuition rate will be $40,000 per year. Anyone attending 20 or more hours of classes during the regular school week (8:30am - 3:30pm) is considered full-time. Students who attend KABAS less than 20 hours per week as a component of their individualized plan toward full-time attendance are considered full-time.

Financial Assistance and Scholarships

We recognize that we are a unique private school and aim to ensure that our services are as accessible as possible to everyone. We encourage you to reach out to organizations to request financial assistance. This past school year, KABAS provided $400,000 worth of scholarships. Unfortunately, the amount in scholarships available for current and incoming students has decreased. This means that our current families and incoming families will have some financial responsibility to help bridge the gap and ensure that KABAS can continue to deliver quality education. Internally, we are working diligently to secure grants from community partners and by holding fundraising events.

Students who require Applied Behavioral Analysis (ABA)

We can accept students who will receive ABA any time provided that they have the appropriate documents. Students must have 1) an insurance provider that we are able to accept, such as BCBS or ASR, 2) have the necessary diagnostic documentation approved by BCBS, or 3) be able to privately pay for services.

Private Pay for ABA

Students who need ABA services, have the required documents, are not receiving services elsewhere or opt to pay privately will be charged Medicaid rates. In this way, we will work with families to make the services as accessible as possible. For more information on this, please contact our billing expert at finance@kalamazooschool.org.

Payment information

- You will receive an invoice for the school year within the first 30 days of school.
- You may choose an annual, quarterly or monthly payment schedule. KABAS will only accept direct payments. We will not accept any cash or check payments.
- Direct deposits will have a $3 fee for processing. To set up your direct deposit and/or autopay options, please email: finance@kalamazooschool.org
- A $50 late fee will be applied for each week payments are late. Exceptions may be made on a case by case basis if arrangements are made ahead of the payment due date.

Emergency Medical Release Form
2026/2027 School Year

Student's name:_____ DOB:_____

(This form must accompany students to hospital in the event of emergency treatment.)

TO WHOM IT MAY CONCERN:
I hereby grant permission for KABAS Academy staff to take whatever steps may be necessary to obtain emergency medical care for my child, if warranted. Depending on the nature and urgency of the situation these steps may include, but are not limited to, the following:

1. Attempt to contact a parent/guardian.
2. If a parent/guardian is not available, we will attempt to contact the local emergency contact listed on this form.
3. Call 911.
4. Any expenses incurred in seeking medical treatment will be the responsibility of the child's family.
5. The school will not be responsible for anything that may happen as a result of false medical or personal information given on this form.

Name of Parent(s)/Guardian:
_____

Mother's Cell Number_____ Father's Cell Number_____

Mother's Work Number _____ Father's Work Number _____

Mother's employer/occupation _____ Father's employer/occupation _____

Name and phone number of a **local** Emergency Contact (if parents cannot be reached)
_____
**In order for someone else to seek urgent care for your child, they will need to have copies of your insurance card and may be required to have a Power of Attorney.

Relationship to Student _____

Telephone Number(s)_____

Parent/Guardian Signature:_____ Date: _____

Physician and Dentist to contact in the event of an emergency:

Name	Phone	Address

Insurance Information:

Insurance Carrier	Policy #

Medical History

Allergies (foods, medicines, seasonal/environmental, insect/bug):

_____

_____

Does your child have an ASD diagnosis:

- ☐ Yes
- ☐ No

Does your child receive ABA therapy:

- ☐ Yes
- ☐ No

List all daily medications:

_____

_____

Do any medications need to be administered at school (if yes, complete “Medical Administration" form)**:**

- ☐ Yes
- ☐ No

List any chronic or severe illnesses, injuries, surgeries, or hospitalizations:

_____

_____

List any pertinent health or safety issues that may be a concern at school:

_____

_____

Does your child use vision or hearing aids:

- ☐ Yes (specify): _____
- ☐ No

Has your child ever been diagnosed with asthma by a physician:

- ☐ Yes
- ☐ No

Does your child carry an inhaler at school:

- ☐ Yes
- ☐ No

Date of Last physical exam: _____

Date of last Tetanus shot: _____

Medication Administration Form
2026/2027 School Year

I _____, give permission for my child _____, to have his or her oral medication(s) administered to him or her during school hours by a KABAS Academy school staff.

My child will need the following medication(s) and dosage(s) administered during the school hours:

	Medication	Dosage	Time
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Instructions for administering the medication(s):

_____

_____

_____

Signed: _____ Date:_____
PHYSICIAN signature required for ALL PRESCRIPTION medications

Signed: _____ Date:_____
PARENT signature required for prescription and over-the-counter medications

Medication must be provided in its original container from the pharmacy with dosage amount, directions, and the name of the prescribing physician. Please note that if the above information is not provided the medication <u>will not</u> be administered.

☐ N/A: This form does not apply to my child.

Signed: _____ Date:_____

I give KABAS staff permission to administer, at their discretion, the following oral medications or their generic equivalents to my child as needed during the school day, at a dose appropriate for his/her age & weight (SELECT FROM LIST BELOW):

- ☐ Tylenol (acetaminophen)
- ☐ Benadryl (diphenhydramine)
- ☐ Motrin/Advil (ibuprofen)
- ☐ Tums (calcium carbonate)

Media Release Form

Throughout the school year, KABAS may take pictures and/or videos for the purpose of staff training, marketing, and advertising. KABAS may also have opportunities to talk about students' academic and behavioral improvements and outcomes at professional conferences or events. By signing this, you are giving KABAS permission to use copies of pictures and recordings for educational, promotional, and advertising purposes. You are also giving KABAS permission to talk about your child's educational improvements. Your child's personal information (e.g., name, age, and address) will not be disclosed. There will be no payment for any promotional materials developed during the school year. By signing this, you agree to release KABAS from liability for any claims in connection with videos or pictures taken. All copies of videos or photos taken will be provided to you before they are used.

I give KABAS permission to use academic and behavioral outcomes, pictures, and videos of my child for the following purposes (please note that your child will receive our best help, whether or not you give permission):

Check all that apply:

- ☐ KABAS Website
- ☐ KABAS Facebook
- ☐ Staff Trainings
- ☐ Educational Conferences/Seminars/Lectures
- ☐ Flyers/Posters
- ☐ My child can have their photo taken, but please protect their identity if using picture (blur or cover face)
- ☐ PLEASE DO NOT TAKE PICTURES OF MY CHILD

Parent/Guardian Signature: _____ Date: _____

Equal Opportunity Employer NONDISCRIMINATION NOTICE

In compliance with Title II, Title IV, Title VI, Title VII of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; Section 504 of the Rehabilitation Act of 1973; the Age Discrimination Act of 1975; the Americans with Disabilities Act of 1990 and its implementing regulations, the individuals with Disabilities in Education Act (IDEA) and its implementing regulations; the Michigan Mandatory Special Education Act; and the Revised Administrative Rules for Special Education, it is the policy of the Kalamazoo Academy for Behavioral and Academic Success (KABAS) that no person shall on the basis of race, color, religion, national origin or ancestry, sex (including sexual orientation or transgender identity), age, disability, height, genetic discrimination, weight, marital or family status, military status, or any other legally protected category be illegally excluded from participation in, be denied the benefits of, or be subjected to discrimination during any program, activity, or service or in employment.

In accordance with Federal regulations, KABAS has appointed Title VII, Title IX, Section 504/ ADA, and Age Discrimination Act Coordinators. Any questions, suggestions or complaints can be submitted in writing by contacting the KABAS Director or KABAS Human Resources Department located at:

2595 N. 10th Street, Kalamazoo MI, 49009

ATT: Margaret Uwayo