

UNION CITY COMMUNITY SCHOOLS

SCHOOL OF CHOICE APPLICATION

2019-20
SCHOOL YEAR

Please return before December 20, 2019 to: Superintendent
Union City Community Schools
430 St. Joseph Street
Union City, Michigan 49094

Student's Name: _____ Grade Applying For: _____

Last Grade Completed: _____ Date of Birth: _____

Parent(s)/Guardian: _____

Address: _____ City: _____ Zip: _____

Home Telephone Number: _____

District of Residence: _____

School Attended Last Year: _____

Suspended/Expelled within last two years: _____ Yes _____ No

If Yes, please explain the reason: _____

Special Education Services: _____ Yes _____ No

Reason for requesting School of Choice: (In submitting request, state specific reason(s) and **all** special needs of your child)

Sibling Information:

Does the applicant have a sibling(s) attending Union City Schools? _____ Yes
_____ No

Name: _____ Grade: _____

Name: _____ Grade: _____

****NOTE****

PROVIDING FALSE OR MISLEADING INFORMATION ON THIS DOCUMENT WILL BE GROUNDS FOR IMMEDIATE REMOVAL FROM THE DISTRICT.

PARENTS WILL BE RESPONSIBLE FOR TRANSPORTATION OF STUDENT(S) FOR INCOMING SCHOOL OF CHOICE STUDENTS.

STUDENTS WHO TRANSFER BY CHOICE FROM ONE SCHOOL TO ANOTHER AND DO NOT OTHERWISE SATISFY THE M.H.S.A.A. TRANSFER REGULATIONS ARE INELIGIBLE FOR INTERSCHOLASTIC ATHLETICS FOR A FULL SEMESTER.

Parent's Signature: _____ Date: _____

For Office Use Only

Date Application Received: _____

Application Approved: _____

Application Denied: _____ Reason:

Applicant/Parent Notified on: _____