Marlette Preschool Program

Application Packet

2021-2022 School Year

Completed applications are due by August 1st.

Please turn in applications as soon as possible to secure a spot in either room. The Health Appraisals may be turned in at a later day, when your child's physical is finished and the appraisal is signed by a doctor. Immunizations must be included and up-to-date to start on the first day of school.

Please Submit With Your Packet:

1. Copy of your child's Birth Certificate
2. Proof of Income: W2 Form, tax statement, or pay stub
3. Proof of Residency: driver's license or piece of mail

Sanilac ISD GSRP

Great Start Readiness Program
Michigan's Nationally Recognized Pre-K Program

This material was developed under a grant awarded by the Michigan Department of Education. Rev. 01-2018

Marlette Preschool Program Details

You will be notified once your child has been placed in a class. It will likely be the end of August before you are contacted. For more information or with questions, please email Nicole Albertson at Nicole.albertson@marletteschools.org.

	GSRP Preschool **Great Start Readiness Program**	Raider Preschool: **Tuition Based Preschool**
Cost of Program	Free to those who qualify based on GSRP criteria	4 Day Program: $1920 a year Can be paid in eight $240 payments. 2 Day Program: $960 a year Can be paid in eight $120 payments
Age of Students	Must be 4 years old by September 1, 2021	3 or 4 Years Old Must be 3 by September 1, 2021
4 Day Program	Monday - Thursday 8:00 a.m. -2:50 p.m.	Monday - Thursday 8:00 a.m. - 11:45 a.m. *Daycare will be available in the afternoon. See below for more info.
2 Day Program	Not offered	Choose from Monday/Tuesday or Wednesday/ Thursday options. 8:00 a.m. - 11:45 a.m. *Daycare is available for the two days the child attends.
Afternoon Childcare	Not needed as GSRP will run all day.	Monday - Thursday 11:45 a.m. - 2:50 p.m. $10.00 for the afternoon
Friday Childcare	Available for $25/for whole day	Available for $25/for whole day
Start/End Date	(Tentative) September 13th 2021 (Tentative) May 19th, 2022	(Tentative) September 13th 2021 (Tentative) May 19th, 2022

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NEMCSA/GSRP Early Childhood Services Application

Program Year _____ Program Preference _____ AM

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_____ _____ _____

* ***Child's First Name*** ***Middle Name*** ***Last Name***

Date of Birth:____/____/____Gender: Female Age & name verified by: Birth Certificate_____Other (specify):_____

Race: *(Check all that apply)* ❑ *American Indian/Alaska native* ❑ *Asian/Asian American* ❑ *Black/African American* ❑ *Caucasian/White* ❑ *Hawaiian/Pacific Islander* ❑ *Other:*_____

Hispanic or Latino: ❑ Yes ❑ No Medical provider: _____ Dental provider: _____

Insurance: ❑ Medicaid / CHIP ❑ State-only funded ❑ Private health insurance ❑ None ❑ Other_____

Primary Name:_____ **Secondary Name:**_____

Date of Birth:____/____/____❑ Mother ❑ Father ❑ Grandparent ❑ Foster ❑ Other _____

Email _____

Phone_____

Education Level (Check highest achieved)
❑ Less than high school graduate
❑ High school graduate/G.E.D.
❑ Some college/vocational school/Associate degree
❑ Bachelor or advanced degree

Employed: ❑ Full-time ❑ Part-time ❑ No
In School/Job Training ❑ Yes ❑ No

Date of Birth:____/____/____❑ Mother ❑ Father ❑ Grandparent ❑ Foster ❑ Other _____

Email _____

Phone _____

Education Level (Check highest achieved)
❑ Less than high school graduate
❑ High school graduate/G.E.D.
❑ Some college/vocational school/Associate degree
❑ Bachelor or advanced degree

Employed: ❑ Full-time ❑ Part-time ❑ No
In School/Job Training ❑ Yes ❑ No

How did you hear about our program? ❑ Facebook/Social Media ❑ Web Search ❑ Flyer/Brochure
❑ Friend/Relative (how they heard)_____❑ Past/Present HS/EHS/GSRP Parent ❑ Other _____

Is mother currently pregnant? ❑ Yes ❑ No ❑ Unknown If yes, due date: _____

List first and last name and birth date of others in the household supported by income of the parent/guardian(s):

1._____/___/___ 4._____/___/___
2._____/___/___ 5._____/___/___
3._____/___/___ 6._____/___/___

Living Address: _____
(Number & Street) (City) (Zip Code)

Mailing Address (if different from above):_____
(Number & Street or PO Box) (City) (Zip Code)

County:_____School District:_____ISD: _____

Primary Language: _____ Active US Military: ❑ Yes ❑ No US Military Veteran: ❑ Yes ❑ No

Referred by a Child Welfare Agency: ❑ Yes ❑ No SNAP: ❑ Yes ❑ No WIC: ❑ Yes ❑ No

Alternate Contact: _____

(Name) (Phone)

Child's Name: _____

Transition Status

❑ Transitioning from EHS (NEMCSA or other grantee) ❑ Transitioning from other than NEMCSA HS/program

Eligibility and Prioritization Criteria (Check all that Apply)

❑ Child is eligible for special education services. (2 – documentation viewed:_____)

❑ Child's developmental progress is less than expected for his/her chronological age.
(2 – documentation viewed:_____)

❑ Child has chronic health issues causing development or learning problems.
(2 – documentation viewed:_____)

❑ Severe or challenging behavior (child has been expelled from preschool or child care center). (3)

❑ Primary home language other than English (English is not spoken in the child's home or English is not the child's first language). (4)

❑ Parent(s) with low educational attainment (parent has not graduated from high school or is illiterate). (5)

❑ Abuse/neglect of child, sibling or parent (domestic, sexual, or physical abuse of child or parent; child neglect issues; substance abuse). (6)

❑ Parental loss due to death, divorce, incarceration, military service or absence. (7)

❑ Sibling issues. (7)

❑ Teen parent (not yet age 20 when first child born). (7- documentation viewed:_____)

❑ Family is homeless or without stable housing. (7)

❑ Residence in a high-risk neighborhood (area of high poverty, high crime, with limited access to community services). (7)

❑ Prenatal or postnatal exposure to toxic substances known to cause learning or developmental delays. (7)

❑ Unemployed parent (currently looking for work). (N/A)

❑ High-quality publicly funded full-day pre-kindergarten (GSRP) is available in area. (N/A)

To increase the likelihood of my child benefiting from a preschool experience, I, parent/guardian, authorize my family/child application/eligibility information be shared with local collaborating preschool education agencies. This authorization shall remain in effect for two (2) years from the signature date. I have the right to revoke, in writing and at any time, said consent. ❑ Yes ❑ No

The undersigned acknowledges they have been notified of Northeast Michigan Community Service Agency, Inc.'s *Notice of Privacy Practices* and has had an opportunity to discuss concerns/questions about the privacy of the information provided. Any changes to the notice will be available at www.nemcsa.org. I certify the information provided in support of this application is accurate and complete to the best of my knowledge.

Parent/Guardian Signature:_____ **Date:** _____

********** AGENCY USE ONLY **********

❑ TANF ❑ SSI
❑ Foster Care ❑ Homeless Number in Household: _____ Family Income: $_____

Information verified and taken by:_____ **Date:** _____

These materials were developed under a grant awarded by the Office of Head Start and Michigan Department of Education.

CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

For Provider Use Only:	Date of Admission	Date of Discharge

Name of Child (Last, First, Middle Initial)			Child's Date of Birth
Address (Number and Street, Building/Apartment Number)	City	State	Zip Code

Parent/Legal Guardian's Name	Home Phone ( )	Parent/Legal Guardian's Name (Optional)	Home Phone ( )
Home Address (if not child's address)	Cell Phone ( )	Home Address (if not child's address)	Cell Phone ( )
City / State / Zip Code		City / State / Zip Code	
Email Address (optional)		Email Address	
Employer Name	Work Phone ( )	Employer Name	Work Phone ( )

Name of Child's Physician or Health Clinic	Physician's or Health Clinic's Phone Number ( )
Hospital Preferred for Emergency Treatment (optional)	
Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary.)	

BCAL-3731 (Rev. 7-18) Previous edition 6-17 may be used.

See Reverse Side

Emergency Contact & Release of Child: List all individuals, including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)

1.	( )	( )
2.	( )	( )
3.	( )	( )

Release of Child Only: List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)

1.	( )	2.	( )
3.	( )	4.	( )

Parent/Legal Guardian Initials:

_____I give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical treatment for the above named minor child while in care.

I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.

Signature of Parent or Guardian — Date Signed

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials

LARA is an equal opportunity employer/program.

AUTHORITY: 1973 PA 116
COMPLETION: Required
PENALTY: Rule Violation Citation.

BCAL-3731 (Rev. 7-18) Previous edition 6-17may be used.

HEALTH APPRAISAL

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 and dentist. (**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) MI	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER ( )
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	WORK TELEPHONE NUMBER ( )

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?
☐	☐	☐	1 Allergies or Reactions (for example, food, medication or other)
☐	☐	☐	2 Hay Fever, Asthma, or Wheezing
☐	☐	☐	3 Eczema or Frequent Skin Rashes
☐	☐	☐	4 Convulsions/Seizures
☐	☐	☐	5 Heart Trouble
☐	☐	☐	6 Diabetes
☐	☐	☐	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements
☐	☐	☐	9 Shortness of Breath
☐	☐	☐	10 Speech Problems
☐	☐	☐	11 Menstrual Problems
☐	☐	☐	12 Dental Problems: Date of Last Exam / /
☐	☐	☐	Other (please describe): _____
☐	☐		Does your child take any medication(s) regularly?

Reason for Medication

Birth History:

Are there any current or past diagnosis(es) ☐ Yes ☐ No

If yes, please describe:

If yes, list medications:

_____ / / _____

Parent/Guardian Signature Date

Was the health history reviewed by a health professional?

☐ Yes ☐ No ***Examiner's Initials:*** _____

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	VISION Date: / /	Visual Acuity			
			Muscle Imbalance			
			Other:			
☐	☐	HEARING Date: / /	Audiometer			
			Other:			
☐	☐	URINALYSIS Date: / /	Sugar			
			Albumin			
			Microscopic			
☐	☐	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl ⇨			

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
☐	☐	Other: _____	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading: _____			
☐	☐	TUBERCULIN Date: / /	Type: _____ Neg.: ☐ Pos.: ☐ _____ mm			

NOTE: Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.

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 on the basis of this information.*

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3
	2	
DTaP/DTP/DT/Td	1	4
	2	5
	3	6
Tdap	1	
Haemophilus Influenzae type b (HIB)	1	3
	2	4
Polio (IPV/OPV)	1	3
	2	4
Pneumococcal Conjugate (PCV7/PCV13)	1	3
	2	4
Rotavirus (RV1/RV5)	1	3
	2	
Measles,Mumps, Rubella (MMR)	1	2
Varicella (Chickenpox)	1	2

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (HepA)	1	2
Influenza (IIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	2	
OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	1	
	2	
	3	

History of Chickenpox Disease? ☐ Yes ☐ No If yes, date:

Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable

*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.

Parent/Guardian refused immunizations: ☐

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)

No	Yes	
☐	☐	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:
☐	☐	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): ☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Other

Other Recommendations

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined _____ child's name 's teeth. As a result of this examination, my recommendation for treatment is: _____

_____ *Dentist's Signature* _____ / / Date

PHYSICIAN'S SIGNATURE

_____ *Examiner's Signature* _____ / / Date _____ *Examiner's Name (Print or Type)* _____ Degree or License

_____ Number & Street _____ City _____ MI ZIP Code (_____) _____ Telephone

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 preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-child care 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.

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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.

Great Start Readiness Program
Michigan's Nationally Recognized Pre-K Program

Sanilac County ISD GSRP Preschool Program
Permission Form

Dear Parent/Guardian of _____
Child's Name

Please read and sign this statement of permission.

- ☐ I hereby grant permission for my child to use all play equipment and participate in all activities of the GSRP Preschool Program.
- ☐ I hereby grant permission for my child to be included in evaluations and pictures connected with the GSRP Preschool Program.
- ☐ I hereby grant permission for the Director, Teacher or Caregiver to take whatever steps may be necessary to obtain emergency medical care, if warranted. These steps may include, but are not limited to the following:
  - Attempt to contact a parent/guardian or other specified person on the child's registration form/child information card.
  - Attempt to contact child's physician as stated on the child information card.
  - Attempt to contact the parents/guardian through any of the persons listed on the child information card you completed for us.

If we cannot contact you or your child's physician, we will do any or all of the following:

- Contact EMS 911
- Have the child taken to the nearest emergency hospital in the company of a staff person.

Please note: You will be responsible for financial expenses if we are unable to contact persons on the child emergency card. This is why it is important to keep your emergency numbers up-to-date with us.

The Sanilac County ISD and the GSRP Preschool Program is not responsible for anything that may happen as a result of false or incomplete information given at the time of registration.

I have read and understand the information in the PARENT PRESCHOOL HANDBOOK.

_____ _____
Parent/Guardian Signature Date

_____ _____
Program Director Signature Date

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Rev. 01-2018

Great Start Readiness Program
Michigan's Nationally Recognized Pre-K Program

Sanilac County ISD GSRP Preschool Program
Discipline Policy

It is our goal to create an atmosphere that encourages children to respect each other and to make positive choices regarding their behavior. In a preschool environment, teaching proper behavior means teaching children how to deal with those around them and to treat others with respect and kindness. Michigan Licensing Rules require our staff to use "positive methods of discipline which encourage self-control, self-direction, self-esteem and cooperation." We will take the following steps until the problem is resolved:

- Staff listens to children having difficulties to determine if they can work out solutions on their own and then encourages them to do so. Children are taught to relate to one another with respect and kindness.
- Staff intervenes and helps mediate a problem with positive suggestions such as taking turns. Children are asked to use words to express feelings rather than actions. Staff will attempt to redirect to another activity, also repeating a statement of positive redirection, they will ask the child or children if he/she will enact the redirected behavior alone or with adult help. The staff will also try to guide children from the situation. Children will be comforted and staff members will try to talk out situations with them.
- The involved parties are given time to remain removed from the immediate setting or situation causing the conflict. They "take a break" until they feel they are able to rejoin the group.
- Parents will be informed of any circumstances involving persistent undesirable behavior in an effort to work together toward a successful relationship:
    - Verbal Conversation.
    - 1st discipline note sent home along with a student/teacher conversation.
    - 2nd discipline note sent home along with parent/teacher conversation.
    - 3rd discipline note sent home along with parent/teacher conference.

I have received a copy and understand the GSRP Preschool Program Discipline Policy.

Please Note: We are required by Licensing Regulation to give parents a copy of our Discipline Policy. See handbook for your copy of this discipline policy.

_____ _____

Parent/Guardian Signature Date

_____

Child's Name

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Field Trip Permission Form

I give my child, _____, permission to participate in
Child's Name

any field trips associated with the GSRP Preschool Program. Families will always receive advance notice of all field trips and will be asked to sign a separate permission form for each trip. This general permission form covers in the event we do not receive a signed field trip form from you and we need verbal permission for your child to participate.

_____ _____
Parent/Guardian Signature Date

Internet/Photograph Release Form

Yes, I give permission for my child, _____, to be
Child's Name

photographed at the GSRP Preschool Program. These photos may also be placed on the schools' website or be used as needed. In addition, local newspapers may occasionally photograph your child.

No, I do not give permission for my child, _____, to
Child's Name

be photographed at the GSRP Preschool Program.

_____ _____
Parent/Guardian Signature Date

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Sanilac County ISD GSRP Preschool Program
Confidentiality Form

I understand and agree that as a volunteer of the GSRP Preschool, I may occasionally view privileged and confidential information. I shall respect the privacy of the children we serve and their families. I will hold in confidence all information obtained in the course of volunteering, whether the information is obtained through reports, records, web-based data or interactions with children or family members. I understand that all information must be kept safe from loss, destruction, theft, and unauthorized use. I understand that the copying of information or removal thereof is strictly prohibited unless authorized for legitimate purposes by a supervisor. I understand that a child's/families' information may be released by authorized personnel and in accordance with the law. When my service with the center is complete, I shall maintain not only child/family but co-worker confidentiality, and I shall hold confidential information about sensitive situations within the center.

I further understand that the divulging of confidential information to unauthorized persons may make me the subject of civil action, as well as disciplinary action up to and including termination.

_____ _____

Volunteer Signature Date

_____ _____

Program Director/ Supervisor Signature Date

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Rev. 01-2018

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Licensing

PARENT NOTIFICATION OF THE LICENSING NOTEBOOK

Child Care Organization Act, 1973 Public Act 116
Michigan Department of Health & Human Services

All child care centers must maintain a licensing notebook which includes all licensing inspection reports, special investigation reports and all related corrective action plans (CAP). The notebook must include all reports issued and CAPs developed on and after May 27, 2010 until the license is closed.

- This center maintains a licensing notebook of all licensing inspection reports, special investigation reports and all related corrective action plans.

- This notebook will be available to parents for review during regular business hours.

- Licensing inspection and special investigation reports from at least the past two years are available on the Bureau of Children and Adult Licensing website at www.michigan.gov/michildcare.

I have read the above statement issued by _____
Name of Child Care Center

I have read and understand all of the policies stated in the Parent Preschool Handbook and agree to all policies stated therein.

Student Name _____

Parent Name _____

Date _____

Parent Signature _____

Please document any discrepancies or disagreements on the bottom of this page.

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Student's Name: _____

School Bus Services

Busing will be available for your child for the beginning and ending of the school day. Busing will NOT be available for students leaving at 11:45am.

_____ My child will not require busing to and from school.

_____ My child will require busing to school.

Pick Up Address: _____

_____

Name and Phone # of Adult: _____

_____ My child will require busing home from school.

Drop off Address: _____

_____

Name and Phone # of Adult: _____

Parent Signature: _____ Date:_____