# Marlette Preschool Program

# Application Packet

## 2018-2019 School Year

**Completed applications are due by August 1st.**

Spots in our program are limited, so please turn your applications in as soon as possible to ensure your child has a spot.

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 middle of August before you are contacted. For more information or with questions, please check out our website:
Marlettepreschoolprogram.weebly.com

| | GSRP Preschool<br>**Great Start Readiness Program** | Raider Preschool:<br>**Tuition Based Preschool** |
|---|---|---|
| Cost of Program | Free to those who qualify based on GSRP criteria | 4 Day Program:<br>$1920 a year<br>Can be paid in eight $240 payments.<br><br>2 Day Program:<br>$960 a year<br>Can be paid in eight $120 payments |
| Age of Students | Must be 4 years old by September 1, 2018 | 3 or 4 Years Old<br>Must be at least 3 by September 1, 2018 |
| 4 Day Program | Monday - Thursday<br>7:55 a.m. -2:50 p.m. | Monday - Thursday<br>7:55 a.m. - 11:45 a.m.<br>*Daycare will be available in the afternoon. See below for more info. |
| 2 Day Program | Not offered | Choose from Monday/Wednesday or Tuesday/ Thursday options.<br>7:55 a.m. - 11:45 a.m.<br>*Daycare is available for the two days the child attends. |
| Afternoon Childcare | Not needed as GSRP will run all day. | Monday - Thursday<br>11:45 a.m. - 2:50 p.m.<br>$10.00 for the afternoon |
| Start/End Date | (Tentative) September 17th 2018<br>(Tentative) May 23, 2019 | (Tentative) September 17th 2018<br>(Tentative) May 23, 2019 |

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# Early Head Start / Head Start / GSRP Application

Program Year _____ Program Preference _____ AM/PM/FD/HB

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_____ _____ _____

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

Date of Birth: ____/____/____ Gender: M / F 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:**_____

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

**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

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

# 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 | Received | # 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

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

**Birth History:**

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

If yes, please describe:

If yes, list medications:

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<br>Date: / / | Visual Acuity | | | |
| | | | Muscle Imbalance | | | |
| | | | Other: | | | |
| ☐ | ☐ | HEARING<br>Date: / / | Audiometer | | | |
| | | | Other: | | | |
| ☐ | ☐ | URINALYSIS<br>Date: / / | Sugar | | | |
| | | | Albumin | | | |
| | | | Microscopic | | | |
| ☐ | ☐ | BLOOD LEAD LEVEL<br>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<br>Date: / / | Type: _____<br>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 |

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

| 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 | |
| | Type of Vaccine(s) | Date of Vaccine(s) |
| OTHER Vaccines Specify Date & Type | 1 | |
| | 2 | |
| | 3 | |

*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
# 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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# 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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Michigan's Nationally Recognized Pre-K Program

## 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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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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# 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 11:45a.m.

____My child wil not require busing to school.

____My child will require busing to school.

Pick Up Address:_____

_____

Phone # of Adult: _____

____My child will require busing home from school.

Drop Off Address: _____

_____

Phone # of Adult:_____

Parent Signature:_____ Date: _____