

Marlette Preschool Program

Application Packet

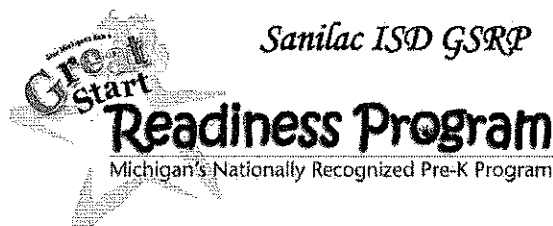
2018-2019 School Year

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



Marlette Preschool Program Details

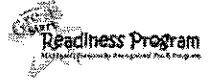
You will be notified once your child has been placed in a class. It will likely be the middle of August before you are contacted. For more information or with questions, please check out our website:

Marlettepreschoolprogram.weebly.com

	GSRP Preschool 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, 2018	3 or 4 Years Old Must be at least 3 by September 1, 2018
4 Day Program	Monday - Thursday 7:55 a.m. - 2:50 p.m.	Monday - Thursday 7:55 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/Wednesday or Tuesday/ Thursday options. 7:55 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
Start/End Date	(Tentative) September 17 th 2018 (Tentative) May 23, 2019	(Tentative) September 17 th 2018 (Tentative) May 23, 2019



Early Head Start / Head Start / GSRP Application



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

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: _____

Secondary Name: _____

Date of Birth: ___/___/___ Mother Father
 Grandparent Foster Other _____

Date of Birth: ___/___/___ Mother Father
 Grandparent Foster Other _____

Email _____

Email _____

Phone _____

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

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

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 / /
PARENT/GUARDIAN (Last, First, Middle)		HOME TELEPHONE NUMBER ()
ADDRESS (Number & Street)	(City)	(ZIP Code) MI ()

SECTION I - HEALTH HISTORY

<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;">No</td> <td style="width: 10%; text-align: center;">Resolved</td> <td style="width: 10%;"></td> <td style="width: 50%;"># Is your child having any of the problems listed below?</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>1</td> <td>Allergies or Reactions (for example, food, medication or other)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>2</td> <td>Hay Fever, Asthma, or Wheezing</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>3</td> <td>Eczema or Frequent Skin Rashes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>4</td> <td>Convulsions/Seizures</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>5</td> <td>Heart Trouble</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>6</td> <td>Diabetes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>7</td> <td>Frequent Colds, Sore Throats, Earaches (4 or more per year)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>8</td> <td>Trouble with Passing Urine or Bowel Movements</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>9</td> <td>Shortness of Breath</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>10</td> <td>Speech Problems</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>11</td> <td>Menstrual Problems</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>12</td> <td>Dental Problems: Date of Last Exam / /</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td colspan="2">Other (please describe): _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td colspan="2">Does your child take any medication(s) regularly?</td> </tr> <tr> <td colspan="5">Reason for Medication _____</td> </tr> <tr> <td colspan="5" style="text-align: center;">_____/_____/_____ Parent/Guardian Signature Date</td> </tr> </table>	Yes	No	Resolved		# Is your child having any of the problems listed below?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1	Allergies or Reactions (for example, food, medication or other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2	Hay Fever, Asthma, or Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3	Eczema or Frequent Skin Rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4	Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7	Frequent Colds, Sore Throats, Earaches (4 or more per year)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8	Trouble with Passing Urine or Bowel Movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10	Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11	Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12	Dental Problems: Date of Last Exam / /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe): _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child take any medication(s) regularly?		Reason for Medication _____					_____/_____/_____ Parent/Guardian Signature Date					<p>Birth History:</p> <p>Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe:</p> <p>If yes, list medications:</p> <p>Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____</p>
Yes	No	Resolved		# Is your child having any of the problems listed below?																																																																																		
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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	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	VISION Date: / /	Visual Acuity Muscle Imbalance Other:				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT Other:	Height Weight Other:			
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: / /	Audiometer Other:				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE	→ Reading: _____			
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: / /	Sugar Albumin Microscopic				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN Date: / /	Type: _____ Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm			
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl				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		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	2
	2			2	3
DTaP/DTP/DT/Td	1	4	Influenza (IV/LAIV)	1	3
	2	5		2	4
	3	6	Meningococcal (MCV4 / MPSV4)	1	2
Tdap	1		Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
Haemophilus Influenzae type b (HIB)	1	3	OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	2	4		1	
Polio (IPV/OPV)	1	3		2	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	3		
	2	4	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable		
Rotavirus (RV1/RV5)	1	3	*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.		
Measles, Mumps, Rubella (MMR)	1	2	Parent/Guardian refused immunizations: <input type="checkbox"/>		
	2		History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: I certify that the immunization dates are true to the best of my knowledge		
Varicella (Chickenpox)	1	2			
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:
<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> Other
Other Recommendations		

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)
I have examined _____'s teeth. As a result of this examination, my recommendation for treatment is: _____ child's name
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 _____

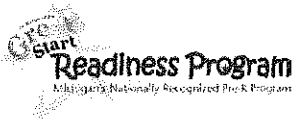
Information required for:

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.

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.



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



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.

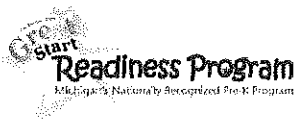
I have received a copy and understand the GSRP Preschool Program Discipline Policy.

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



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

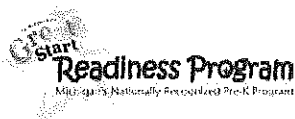
photographed at the GSRP Preschool Program. These photos may also be placed on the schools' website or be used as needed. In addition, local newspapers may occasionally photograph your child.

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

be photographed at the GSRP Preschool Program.

Parent/Guardian Signature

Date



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

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 will 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: _____

